



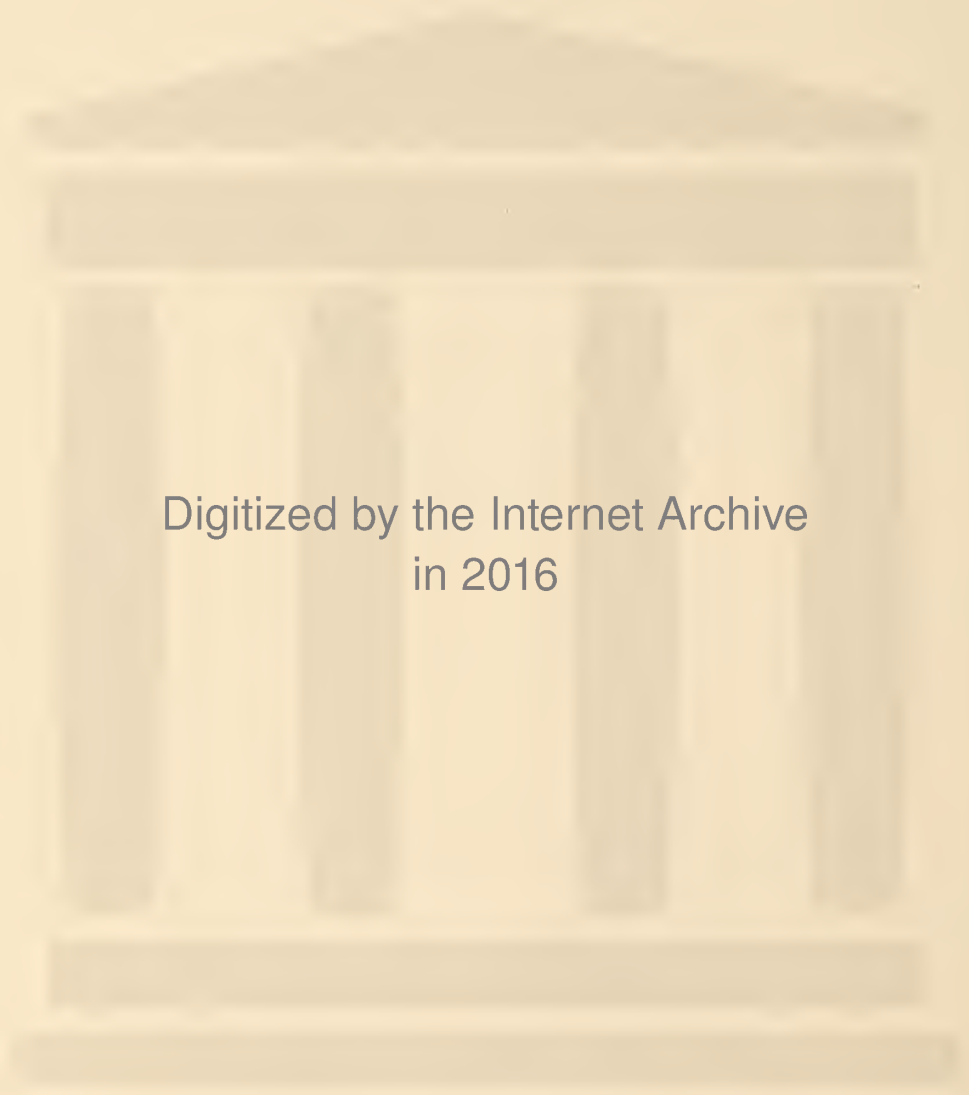
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# THE JOURNAL

OF

## THE MEDICAL SOCIETY OF NEW JERSEY

Index



1942

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Editorial Office  
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1942

# The Journal of The Medical Society of New Jersey

## Volume 39

### HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (\*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject, book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

If you do not bind your Journals, use the table of pages (below) to find the month of issue to which any page citation refers.

The Official List of Members and Fellows will be found as the supplement to the May issue. The Transactions of the Annual Meeting appear as a supplement to the August issue.

A special index to the Transactions will be found on the first page of the Transactions supplement. The annual reports of the committees and officers of the Society are indexed on page 184 of the April *Journal*.

### TABLE OF PAGES

January	1 to 56	September	465 to 516
February	57 to 128	October	517 to 566
March	129 to 182	November	567 to 614
April	183 to 248	December	615 to 676
May	249 to 310	Annual Reports	April Journal
June	311 to 360	Official List	May Supplement
July	361 to 414	Transactions	August Supplement
August	415 to 464		

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\* Original Articles  
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ab—Abstract

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### CONTENTS—Pages 1 to 56

#### EDITORIALS—

	Page
THE LIGHTS HAVE GONE OUT	1
AN AFFIRMATIVE PROGRAM	2
MEDICINE IS READY	2
COMMUNITY PARTICIPATION BY THE PHYSICIAN	3

#### THE WAR—

Enrollment Form for Physicians	4
A Call to the Colors	5
THE DOCTOR IN THE ARMY—Robert A. Kilduffe, M.D., Atlantic City	5
Health Department to Participate	8
Civilian Medical Defense in New Jersey	9
THE HOSPITAL IN CIVILIAN DEFENSE—H. Van Zile Hyde, M.D., New York	12
Physicians Wanted as Instructors	15
The Medical Society and the Defense Program	16
The Pharmacy and Civilian Defense	16
Mental Disease in the Army	18

#### ORIGINAL ARTICLES—

ERYTHREMIC RESPONSE TO LIVER THERAPY—Paul Fertary, M.D., Totowa, N. J.	19
ANO-RECTAL PAIN, ITS CAUSES AND TREATMENT—Julius Gerendasy, M.D., Elizabeth, N. J.	21
DIFFERENTIAL DIAGNOSIS BETWEEN ACUTE DISEASES OF THE CHEST AND OF THE ABDOMEN—George P. Muller, M.D., Philadelphia	27
DIFFERENTIAL DIAGNOSIS IN PERIPHERAL VASCULAR DISEASE—Ferdinand C. Dingel, M.D., East Orange, N. J.	30
ACCIDENTS OF CHILDBIRTH AS A CAUSE OF MATERNAL MORTALITY IN NEW JERSEY—Maternal Welfare Article No. 66—Arthur W. Bingham, M.D., East Orange, N. J.	33

#### STATE ACTIVITIES—

	Page
Proposed Constitutional Amendment	36
Ocean County Transfusion Fund	36
Moving Pictures for Annual Meeting	36
Passaic County Radio Project	36
Portrait of Dr. Haussling	36
New Jersey Physicians' Committee	38
Dr. Prout Honored	40
Academy of Medicine of Northern New Jersey	41
Improvement in School Medical Service	41
Traffic Accidents Committee	42
Obituaries	42

#### COUNTY SOCIETY REPORTS—

Atlantic, Bergen, Burlington, Camden	43
Cumberland, Gloucester, Mercer	44
Middlesex, Monmouth, Morris	45
Passaic and Salem; Summit Medical Society	46

#### WOMAN'S AUXILIARY—

Coming Events	47
"E" Is for Essex	47
The Bulletin	48
Public Relations	48
County Auxiliaries	48

#### THE BOOK SHELF—

Books Received	49
Book Reviews	50

#### NEWS ITEMS—

The Bulletin Board	53
Personal Notes	54

#### TUBERCULOSIS ABSTRACTS

55

Roster of Officers and Committees, Advertising Pages 3A-8A

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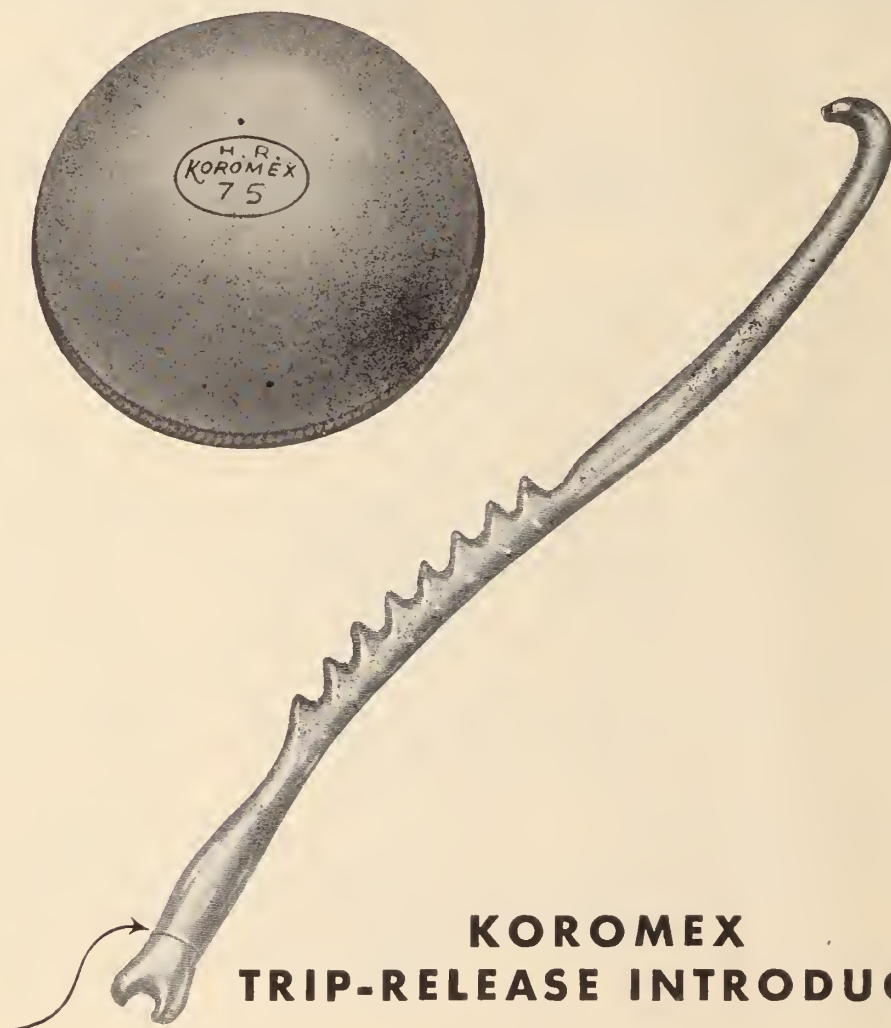
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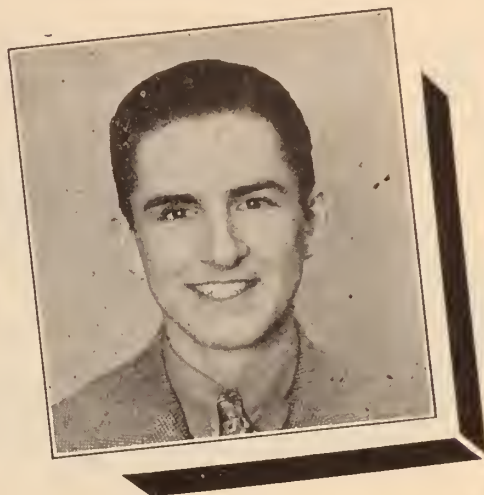
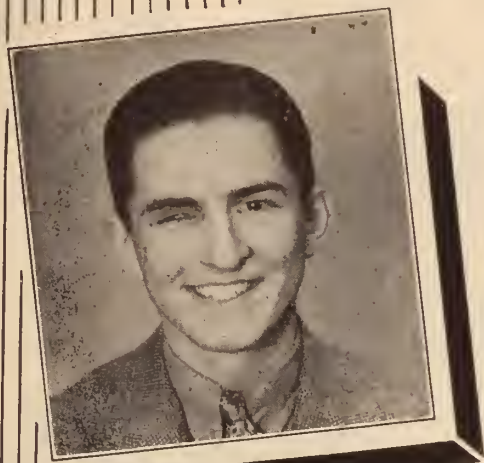
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\**J.A.M.A.*, 93:1110, October 12, 1929

*Bruckner, Die Biochemie des Tabaks*, 1936

\*\**The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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- (1) 1932. J. Am. Med. Assoc. 98, 1429  
1938. Nutrition Abstracts and Reviews 8, 281.  
1938. J. Am. Med. Assoc. 110, 650.  
1940. J. Am. Diet. Assoc. 16, 891.



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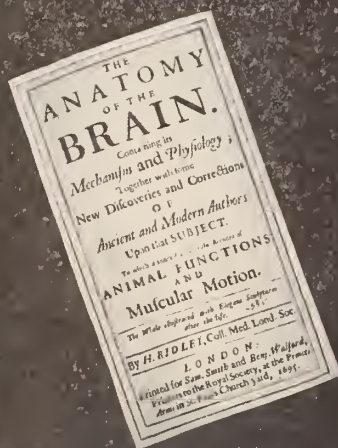
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1. Council Report: J.A.M.A., 113: 1734, 1939

2. Merritt, H. H. & Putnam, T. J.: A. J. Psychiat., 96: 1023, 1940

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Controlled observations\* of 118 cases of pulmonary tuberculosis over a period of 12 to 20 weeks.

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COCOMALT tested against milk alone or cocoa flavored milk for supplementary nourishment.

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	WEIGHT INCREASE	HEMOGLOBIN INCREASE
COCOMALT Test Group . . .	50%	48%
Control Group . . .	21%	27%

*Note that the percentage of patients gaining weight in the test group was more than twice that in the controls.*

8-10 WEEKS AFTER THE STUDY WAS CONCLUDED, additional checks were made on several patients. Results—none of the COCOMALT test group showed any significant gain in weight following

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\*Matsuzawa, D; Boyd, L. J.  
New York Medical College and  
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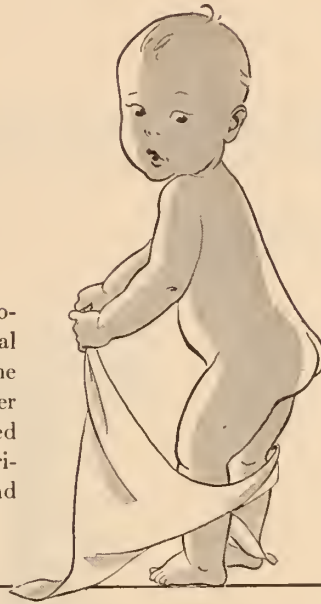


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WITH THE sole exception of vitamin C, Biolac provides completely for the formula needs of normal infants throughout the entire bottle period. From the time when infants consume a full quart of formula per day, here's how certain essential food factors supplied by Biolac feedings compare with the minimal nutritional requirements recognized by the U. S. Food and Drug Administration.



	MINIMAL REQUIREMENTS	BIOLAC FEEDINGS
PROTEIN (gms./lb. body weight) . . .	1.4 to 1.8* . . .	2.2†
CALCIUM (gms./day) . . . . .	1.0* . . .	1.0
IRON (mgms./100 calories) . . . . .	0.75 . . .	1.25
VITAMIN A (U.S.P. Units/day) . . . .	1500. . . .	2500.
VITAMIN B <sub>1</sub> (U.S.P. Units/day) . . . .	83. . . .	85.
VITAMIN B <sub>2</sub> (mgms./day) . . . . .	0.5 . . .	2.
VITAMIN D (U.S.P. Units/100 calories) .	50. . . .	63.

\*The Food & Drug Administration has not promulgated minimum requirements for protein and calcium in infancy. The values shown are those recommended by the National Nutrition Conference.

†When Biolac formulas are fed in the amount of 2½ fl. oz./lb. body weight.

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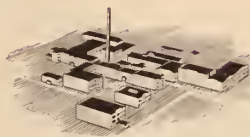
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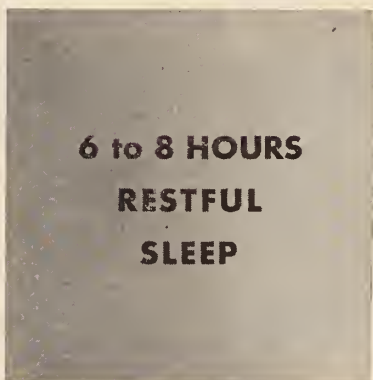
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## "BLOW"

Besides all the well-known discomforts usually associated with a cold in the nose, there is one to which many pay little attention . . . irritation of the nose from continued blowing and wiping. How often do you hear, "My nose is so sore I can't wipe it"?

**NUPERCAINAL**, "Ciba" quickly and efficiently alleviates the soreness of the nasal outlet produced by the irritating discharge and wiping. Its use makes a cold somewhat less uncomfortable.

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ONE OUNCE TUBES

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Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
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Alumina	7.14	4.98	6.37
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Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



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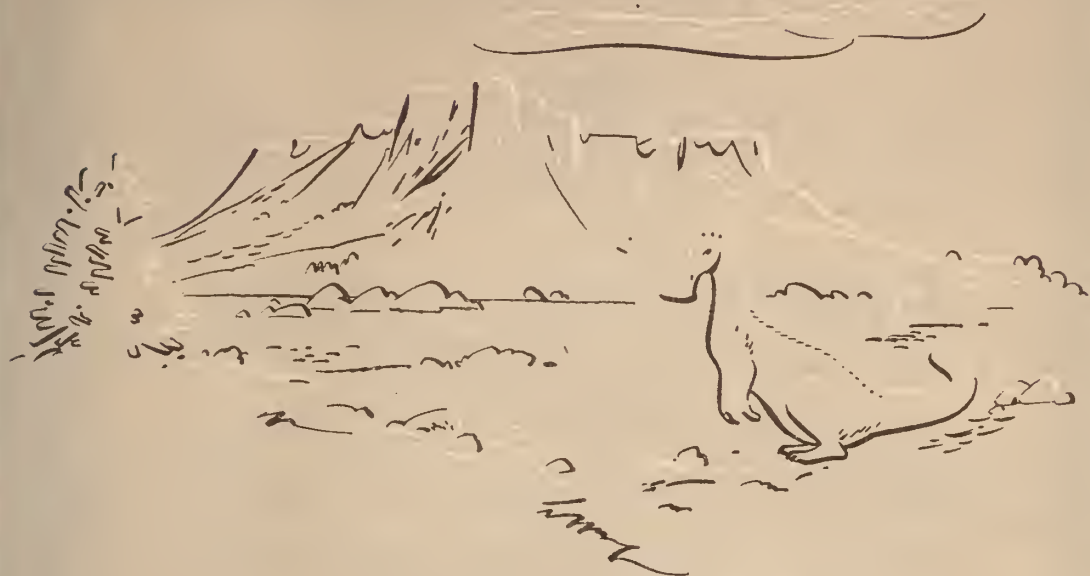
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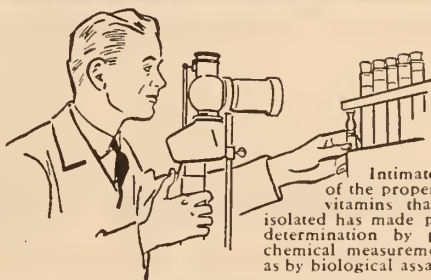
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# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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JANUARY, 1942

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## THE LIGHTS HAVE GONE OUT

Here too, the lights have gone out and we are now plunged into the spiritual gloom and literal black-out of war.

This is a dirty, cheerless task. Like the excision of a putrid abscess, it is a job that must be done. We doctors have a special stake in it, for we are going to wipe out a regime which destroys life, degrades science, and stifles intellectual pursuit. Beneath an Axis boot we could never practice medicine in that scientific and free fashion which has raised our work to its present level. Human dignity, political freedom and a respect for the truth: these are things we live by. Without them, our calling becomes a mockery.

Nor are we non-combatants. We are combatants because we fight, as all scholars must, for the right to intellectual freedom. We are combatants because a bursting bomb does not respect the caduceus on the uniform. We are combatants because, bound by oath to

wage war on disease and death, we must fight those diseased minds which seek to sow the seeds of death throughout the world.

Yet in another sense we are non-combatants. For even in war, the individual under medical care becomes once more a human being. We devote our skill to the sick man, whether he be fellow-soldier or enemy. We do not have one kind of therapy for the stricken American, another for the sick prisoner of war. This is true, it seems, of the physician only. Other branches of the service must treat friends in one way, foes in another. But we doctors can keep faith with our Oath of Hippocrates as well as with our Oath of Allegiance. The learning of the chemist and the engineer must be diverted to the destruction of a malevolent and ruthless enemy. Our science alone retains undimmed its succoring, life-saving, pain-sparing character. And this is, perhaps, the one faint gleam in a blacked-out world.

## AN AFFIRMATIVE PROGRAM

The charge is sometimes made that medical organizations criticize plans for cheapening the distribution of medical care, without offering any constructive suggestions for the improvement of health facilities. The Medical Society of New Jersey, however, is invulnerable to such a charge, since the Medical Service Administration is clearly an affirmative and constructive effort to meet the need.

The people of the State of New Jersey, acting through their chosen representatives in the Legislature, have exhibited their confidence in the physicians of the state by entrusting them with the responsibility of planning and organizing such a program. The Medical Society of New Jersey has shown that it does something more than merely talk about the problem. It has translated criticism and conversation into real action.

While the Medical Service Administration enjoys a corporate existence largely independent of The Medical Society, the fact is that its development was the result of many years of intensive study

manned and financed by members of The Medical Society of New Jersey; and that our Society still accepts a major share of the responsibility for shaping the program of the Medical Service Administration.

Our shift into a wartime economy will lessen the problem of medical care for the indigent—a need which New Jersey doctors have always met adequately in the past and will continue to meet adequately in the future. On the other hand, the pouring of a large number of workers into industry will swell the ranks of wage-earners and throw into more vivid focus the problem of medical care for the family for whom major surgery or catastrophic illness must spell financial calamity.

Thus it is probable that the difficult days ahead will increase the need for the kind of program which the Medical Service Administration can render. New Jersey medicine is fortunate in having the opportunity for continued public service in a time that will try us all.

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## MEDICINE IS READY

The importance of organized medicine to the public has been sharply highlighted by the swiftness and efficiency with which the American Medical Association and the state societies have put their machinery at the disposal of the Government. The A. M. A. has available a completely tabulated, readily accessible census of medical man-power in this country. This enormously simplifies the Government's task of finding physicians for military and civilian defense needs. If there were no central medical organization in the country, and no component societies to collect and organize the data, the process of rapidly securing and assigning thousands of doctors would have been a chaotic one.

Let it be noted that the Army and the Navy properly insist that their Medical Corps be made up exclusively of fully licensed physicians, alumni of top-notch medical schools. There is no "second team" in the medical personnel of the armed forces. Only the holder of an M.D. degree, possessed of an unlimited license, is commissioned to render medical care to our soldiers and sailors. The insistence of the War and Navy Departments on this high standard is, of course, to be commended. The civilian population is entitled to equally sound health protection.

The medical needs of the Army and Navy are too obvious to require listing here, and too pressing to require exhor-

tation. Less glamorous perhaps, but equally important, are the medical aspects of civilian defense, civil service, and attention to the noncombatant population. The care of the sick and injured, military or civilian, in peace or in war, is the responsibility of the medical profession. We have shown that we can put at our country's disposal the scientific learning, the practical skills, and the administrative ability which an all-out health-protection program demands. The physicians of the nation will provide a corps of instructors in first aid. Since it is hoped that ten percent of the civilian population will be trained in first aid, the tremendous contribution which the medical profession can make here is apparent.

Civilian Defense plans properly and necessarily include a health and medical program. Details of this, outlined on page 9 of this *Journal*, will give some idea of the complexities and many-sidedness of the problem.

Since this is a war in which every civilian is on the front line, it represents the hugest medical program that our country and our profession have ever had to meet. Never before has it been necessary to call on 100 per cent of the medical profession. And in no previous war has the medical profession been given a grimmer responsibility or a more important duty. It is perhaps, the largest task which we doctors have ever faced. We are ready for it. We shall do it and do it well.

---

### COMMUNITY PROJECTS

The mood of sober unity which now prevails throughout the United States serves as a reminder—if one is needed—that the medical profession is not a discipline apart, but is woven into the warp of the community. Now, in the dynamic drive of war, we are gearing our activities into national affairs. We see how every problem of fighting and of civilian defense has its medical aspect. Do we also see how every problem of interest to the doctor has its communal aspect, too?

An excellent example of smooth coordination between medical and communal activities is furnished in the history and operation of the Ocean County Transfusion Fund described on page 36 of this issue. Here is an idea conceived by a doctor, promoted by the County

Medical Society, sponsored by the Woman's Auxiliary, supervised by a chartered group which includes non-medical members, and benefiting the public at large. A few other joint projects can be cited. The participation of the Academy of Medicine in the Town Hall of Essex County, for example. The enlistment of medical organizations in government-bond purchasing drives is another instance. These are some examples of Organized Medicine's intimate participation in community (as distinct from governmental) activities.

The war has served to throw into clear light the fact that we are part of the community. An important part, we know; a leading part, we hope. We can secure and hold such leadership only by active participation in our community's functions.



**PROCUREMENT AND ASSIGNMENT SERVICE****ENROLLMENT FORM**

Dr. Sam. F. Seeley, Executive Officer  
Procurement and Assignment Service  
New Social Security Building, "C" Street at 4th Street  
Washington (S. W.), D. C.

Dear Doctor Seeley:

Please enroll me as a physician ready to give service in the Army or Navy of the United States when needed in the current emergency. I will apply to the Commander in the Second Corps Area when notified by your office of the desirability of such application.

(Signed) .....

1. ....  
Last Name (Print or type) First Name Middle Name
2. 3. Born in..... at .....  
Month, Year City State, Province Country
4. 5. ....Married; .....Single; .....Widowed; Number of children.....
6. Do you believe yourself able to meet the physical standards for the Army and Navy Medical Corps? .....
7. Have you filled out previously the questionnaire sent to all physicians by the American Medical Association? .....
8. Graduated in ..... from the .....  
Year Name and address of your medical school
9. Licensed to practice in the State of ..... since .....
10. Do you now hold any position which  
might be considered essential to the .....  
maintenance of the civilian medical .....  
needs of your community? If so, state .....  
these appointments. ....
11. Have you previously applied for entry into the Army or Navy Medical Service? .....  
.....Yes. ....No. If the answer is "yes" please state: When.....  
Where .....  
What result? .....  
If application was rejected, what reason was given? .....

....., M.D.  
Please sign your name here

DATE TODAY....., 1942.

THE JOURNAL OF THE  
MEDICAL SOCIETY OF NEW JERSEY

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## THE WAR

### A CALL TO THE COLORS

On the opposite page is a blank by which every physician may at once place his name with the Procurement and Assignment Service as one ready to serve the nation as the need arises.

If you wish to make yourself available for classification, fill out this blank at once—or better yet, write to the Executive Offices in Trenton (143 East State Street) for a reprint of the blank, so that you can send it on without mutilating the *Journal*.

The blank, properly filled in, should be sent to:

Dr. Sam F. Seeley, Executive Officer  
Procurement and Assignment Service  
New Social Security Building  
"C" Street at 4th Street (S.W.)  
Washington, D. C.

These blanks will then be classified and checked with the information available in the national roster of physicians at the Chicago headquarters of the American Medical Association.

Last month the age ceiling for Selective Service was raised from 28 to 45. This places thousands of physicians in the category of those on whom the nation may call as their services are needed. It is estimated, in fact, that about 60,000 physicians in this country will thus become available. By enrolling with the

Procurement and Assignment service immediately all physicians (particularly those under 45) insure to every extent possible, their assignment to the type of service to which they are best fitted: they avoid the possibility of unclassified service with the Army during the period that may follow induction through Selective Service. A physician called by Selective Service who has not enrolled with Procurement and Assignment (by filling and forwarding this blank) will serve without commission during the time that necessarily elapses before a commission is secured.

If you fill out, sign, and forward this blank or its reprint, you will indicate that you are available for service according to the special abilities and preferences reflected in the answers to the questionnaire originally sent to you by the A. M. A. When the Government needs you, the Procurement Service will then notify you that a man of your qualifications is wanted, and you will then apply to the commander in the Second Corps Area.

The medical profession has talked much of its readiness to serve. Here is the chance to implement these words by action. Fill out this blank now, or send a postcard to the Society's office in Trenton asking for a reprint of the blank—and fill that out, and send it to Washington. Do it today.

---

## THE DOCTOR IN THE ARMY

---

By ROBERT A. KILDUFFE, M.D., Atlantic City, N. J.

It now appears likely that many physicians entirely unfamiliar with the varied duties of the military medical service will be required for service with the armed forces. It seems proper therefore that doctors should now envisage the various adjustments which temporary severance from their civil life will induce. Such adjustments should not be allowed to overshadow the fact that the medical profession in time of war enjoys privileges granted to but few professions under similar circumstances.

Medical students of satisfactory calibre are placed in deferred categories by the Selective

Service officials as also are recent graduates serving as internes.

Physicians serving as commissioned officers are employed in capacities directly related to and conducive to valuable experience in their professional work. More than this, the military surgeon has the inner satisfaction of knowing that, if his responsibilities are great and varied, they are also distinctive in that upon his honesty of purpose, his efficiency and his faithful performance of duty the efficiency and morale of the soldier in general may well in large measure depend.

It is readily admissible that to enter upon a

new and unfamiliar environment, to assume in many ways a new mode of life and action, to leave an assured present for an indefinite future may well engender some anxiety and uncertainty of purpose. And, as doctors have an inherent and natural pride in their professional proficiency, there may well be some reluctance to contemplate new and unknown responsibilities for which one may not feel well prepared.

Nevertheless, the march of world events has made this choice mandatory for many of us. Those upon whom the choice may fall, and to whom the opportunity to serve may be given, may find this cursory survey of military medicine of some interest.

It is not intended, nor is it necessary, to discuss the duties of the military surgeon in any detail. Service manuals and Army Regulations, together with the official publications of the Surgeon General and the War Office will supply all the necessary information required by the new officer, and actual field training will supply experience.

#### THE LITTLE BLACK BAG

It is the purpose of this article to call attention to certain inherent differences between *civilian* medical practice and *military* medicine which may, at first glance, appear confusing.

It is essential to appreciate that military medicine cannot be practiced with the "little black bag" and its accessories which stand as the symbol of the civilian doctor.

#### BATTLE CASUALTIES

To the uninitiated the military surgeon connotes the battle casualty. Perhaps the picture presents as a series of events: first aid on the battlefield; transportation to the rear by ambulance, further care in well-equipped and well-staffed hospitals and a final return to duty after discharge from the hospital.

Such a concept would be, in its broad outlines, quite correct. But, as picturing the work of the military surgeon it would be far from complete. For in addition to these duties, for which the civilian doctor may be well and adequately trained, the military surgeon has other added and, in general, equally important responsibilities which are here briefly outlined.

#### SANITATION

For the prophylaxis of disease by appropriate sanitary measures, the medical officer must be informed upon such matters as the construction and policing of latrines, the disposal of waste and garbage, the elimination of flies, the care of the soldier's feet, the protection of water supplies, the purification of potable waters in the field, etc.

#### EVACUATION

The collection, evacuation and treatment of sick and wounded in all theatres of war is also his function. The medical officer may have to acquire the ability to read maps; plan, organize and administer such operations; issue clear, fool-proof orders and utilize no small measure of executive and administrative ability.

#### ADMINISTRATION

The medical officer functions in the provision and distribution of medical equipment and supplies. In this capacity he must learn how to assume and discharge property responsibility; how to dispose of property by survey; and, most important of all, how to estimate what kind and how many supplies may be needed under a particular set of circumstances. During war, supply and demand may be disproportionate and, even when the supply is ample, its rapid and efficient distribution may present difficulty and require careful planning and stopwatch adjustment of method and means.

#### MORALE

Efficient medical organization is a means for the maintenance of morale by the consciousness that immediate medical aid will be at all times available to officers and men of combat forces. To this important end the medical officer must of himself and in himself engender in his men and the organization to which he is attached a deserved belief in his efficiency and a complete confidence in his ability, not only as a doctor, but also as an officer. Such respect must be earned for few are quicker than the soldier to distinguish between efficiency and officiousness; between authority and its abuse; between the man and the poseur.

## PAPER WORK

The proper preparation and preservation of official records is generically the "paper work" detested by so many inexperienced officers. It is, however, of great and lasting importance. For, in large and important measure upon the honesty and care with which "paper work" is done, not only will valuable future statistics depend, but without it, adjudication of claims for sickness and injury with justice to both soldier and government may later be well nigh impossible.

## LEARNING AND TEACHING

As for the efficient carrying out of these responsibilities, the medical officer may often be largely dependent in lesser or greater degree upon his commissioned and enlisted personnel, he may also have to assume the training of such personnel. This will apply particularly to officers in command of medical units or detachments whose efficiency as a whole must depend upon the care and degree in which they have been trained in their duties.

Nor is this all. The medical officer with a relatively stabilized unit may find himself a member of a Court Martial, a Mess Officer, Property Officer or in charge of a Company Canteen, all of which may tax his resource and ability and require special knowledge and training not naturally acquired by civilian medical practice.

Now all this may seem very confusing and a far cry from civilian medical practice, as, indeed, it is. But, just as the new artillery officer must have opportunity to learn the technical and intricate details of a weapon perhaps entirely new to him, so the new medical officer will have courses designed to familiarize him with varied and unaccustomed duties and responsibilities. The physician need have no fear of not making good for lack of training and experience for these courses are given to him early in his military career. Others—many others—have learned and so will he, providing he has the will to learn. For there is an old axiom which applies to almost any endeavor: you "get out" of anything in proportion to what you "put into" it.

Of one thing the medical officer can be as-

sured: No matter what may be his post or assignment and no matter how varied his duties, he will never, if he is interested and conscientious, be divorced from his professional work and he will return to civilian life and practice enriched in experience.

The medical officer with troops has a unique opportunity to put into practice and to develop that faculty of observation which his teachers emphasized during his student days—and which, indeed, is the essential requisite to the successful and intelligent practice of medicine; only from keen use of the faculty of observation can any understanding of humanity be acquired.

## HUMAN RELATIONS

In the observation of the reaction of the new recruit to military environment and training, the medical officer will have many opportunities to aid in the making of a soldier. He will soon appreciate the importance of some practical knowledge of psychiatry in the differentiation between organic and functional disease. The frequent observation of the soldier at sick-call gives ample opportunity for an evaluation of character, temperament, intellectual qualification and mental and physical capacity. All this is important and readily applicable to later civil practice.

Soldiers are human beings and soon exemplify—and put into practice—the old adage that the best way to know a man is to live with him for a while.

The soldier soon senses inexperience and takes advantage of credulity and there will be those who will "put something over" if they can.

Under the rigors, stresses and sometimes the monotony of military service, the individual reactions to disease, disability and injury will present many unique features for study. Some will be reluctant to "give in" to ailments, others will now and then try to magnify trivial complaints. These are not always true shirkers but, whatever the motive, if successful, such men may eventually demoralize a whole outfit. The medical officer alone can detect and control them.

The medical officer has a unique relation,



not only to the soldier in general, but to his own superior officers. He must serve as adviser upon all matters relevant to the preservation of health and the prevention of disease. Upon his considered advice and professional knowledge, not only of medicine in general, but also of military medicine in particular, the dissipation or conservation of effective man power may depend in important degree. It should be his desire, therefore, to be as efficient a military doctor as he was a civilian doctor, realizing that efficiency in one sphere is not necessarily synonymous with efficiency in the other.

Just as the doctor in civilian life prides himself on being a "family doctor" and knowing his patients from all angles, so the efficient medical officer will know his soldiers. He will become identified with their training, their interests, their routine. He will take pride with them in understanding the weapons they use, the vehicles they drive, the problems they face. He will march with them, enter into their relaxations, and if he succeeds in his endeavor, he will be a tower of strength in their hour of trial, not only as a professional succour to injury, disease or wound, but, best of all, as a man, a soldier and an officer as well as a doctor.

Not only will he insensibly gain the respect and even the affection of his outfit—and will learn, many years later, how these have endured—but he will gain in wisdom and knowledge by this personal and intimate contact with men of all types under all conditions. For, with all his other responsibilities, the true physician—civilian or military—should be philosopher, friend and guide as well as doctor.

#### PERSONAL SACRIFICE

But all this can come about only if the medical officer gives of himself whole-heartedly and without stint. If this be true, all else will follow: promotion, honor and, greatest of all, the consciousness of having given the best there is in him, not only as a doctor but as a man and a soldier.

It can be frankly admitted that the army doctor has few opportunities to grow rich in the practice of his profession. This is equally true of civil practice.

But the doctor who enters the army in response to a state of emergency does not give much thought to the acquisition of riches. On the contrary, his action frequently means a definite loss of income and a definite sacrifice. While seldom, indeed, a professional flag-waver, and definitely annoyed to be pointed out as a patriot—that hackneyed and abused term!—he knows there is a job to be done and a duty to be fulfilled—and he does it.

#### THE DOCTOR'S ROLE

Now that war has come to the United States the doctor may—and as he always has, will—play an important part in its ultimate determination.

The medical profession of the United States has never yet been called upon in vain and can be relied upon to do its full duty to the country in the preservation in the years to come of all that the United States has stood for and symbolized in the years that have gone. For of us, of all people, will it always be true that we would "rather die on our feet than live on our knees".

108 South Nassau Avenue

### HEALTH DEPARTMENT TO PARTICIPATE

Dr. J. Lynn Mahaffey, Director of the Department of Health of the State of New Jersey, has made available to Dr. Schlichter, Chief of Emergency Medical Service, State Defense Council, and Dr. Norman M. Scott, his associate, any professional or technical employee in his department. This is in accordance with a resolution unanimously adopted by the Department of Health on December 17, 1941. Dr. Schlichter and Dr. Scott are thus authorized

to call directly upon the employees of the Health Department for services, in the event of extreme emergency, without sending the request through the usual channels, though subject, of course, to the subsequent approval of the Director. The arrangement is on a 24-hour basis. To implement the decision, Dr. Mahaffey has furnished Dr. Schlichter and Dr. Scott with a complete roster of all professional and technical employees of the Department.



## CIVILIAN MEDICAL DEFENSE IN NEW JERSEY

Dr. Charles H. Schlichter has been named Chief of Emergency Medical Services and Dr. Norman M. Scott is his Associate.<sup>1</sup> The following information has been released by Dr. Schlichter and Dr. Scott (December 8, 1941):

### NOTICE TO HOSPITALS

New Jersey Defense Council directs that all New Jersey Hospitals organize immediately for Emergency Medical Service for Civilian Defense according to the plan outlined in Medical Division Bulletin No. 1, U. S. Office of Civilian Defense, as altered to fit the needs of New Jersey.

### CASUALTY STATIONS

Casualty Stations will occupy a predetermined site such as the clinic of a hospital, health department or voluntary agency, a health center or substation, a school basement or other suitable place which provides shelter, protection and accessibility. It should be located if possible on a side street so that ambulances will not block main thoroughfares. The sites selected for Casualty Stations should be numbered and indicated on a spot map of the community. The Casualty Station will:

1. Serve as a center from which medical teams may be sent closer to the disaster if required.
2. Care for the less severely injured and for persons suffering from shock or hysteria until they may be permitted to return to their homes or to temporary shelters. This will protect hospitals from the burden of minor casualties which would interfere with the work of caring for the seriously injured.
3. Keep a record of all persons treated at the Station and see that all casualties transferred to a hospital are tagged.

Upon arrival at the site of a disaster, the squads of the Emergency Medical Units which have responded to the appropriate alarm will set up Casualty Stations at the sites designated by the local Director of Civilian Defense. Stretchers, cots, and blankets will have arrived in a truck carrying the Rescue Squad of the police, fire, or other municipal department. Until released by the local Director of Civilian Defense, the physicians and nurses of the Emergency Medical Unit should remain at their station, to which the injured will be directed or transported on stretchers by the Rescue Squads and volunteers enlisted by them for this purpose. The work of the Casualty

Station is to be limited to emergency first aid procedures—the relief of pain, prevention of shock, control of hemorrhage, care of burns, application of simple splints and of surgical dressings and, not least, the preservation of morale by the establishment of confidence. The seriously injured will be evacuated as rapidly as possible by ambulance or other vehicle to a hospital. Those with minor injuries will go to their homes or to temporary shelters.

### FIRST AID POSTS

If necessary, the squad leader in charge of a Casualty Station may split off one or more teams of one physician and assistants, dispatching them to set up subsidiary First Aid Posts at other sites.

It will be advisable for the local Chief of Emergency Medical Service to prepare a spot map of the area to indicate all out-patient clinics, health centers and their substations, and all police and fire stations or other sites which could serve in an emergency as Casualty Stations or First Aid Posts. He should also maintain an inventory of available transportation.

The First Aid Post will occupy a temporary location usually close to the scene of disaster and will:

1. Care for the more severely injured, preparatory to their transfer to a hospital. No surgery other than emergency first aid is contemplated.
2. Classify the casualties so as to expedite the transfer of the seriously injured to a hospital—a most important responsibility which requires surgical judgment.
3. Direct the stream of ambulatory and of slightly injured stretcher patients and those suffering from shock or hysteria to a Casualty Station.
4. Tag all casualties immediately. Maintain entries in the Casualty Record Book of all persons receiving first aid. A nurse or nurse's aide is to be responsible for these records.

### PERSONNEL

1. In hospitals of less than 200 beds, it is recommended that the Emergency Field Unit consist of two squads, one for each 12-hour shift of the day. Each squad should be composed of two physicians, two or more nurses, and two or more orderlies or nurses' aides, and be capable of functioning, if necessary, as two separate teams. At least one Unit of this size is advisable for a population up to 25,000.

2. In hospitals of 200 to 350 beds the Emergency Field Unit should consist of two squads of four doctors, four or more nurses, and four or more orderlies or nurses' aides,

1. New Jersey lies in the Second Civil Defense Region. Medical Officer for this Region is Dr. H. van Zile Hyde, 111 Eighth Avenue, New York City.

one of the physicians in each squad to act as squad leader. Each of the squads should be on first call during a 12-hour period of the day. The personnel and equipment of a squad should be divisible into four teams, capable of functioning if necessary at separate sites of disaster. At least one Unit of this size or two Units with small squads are advisable for populations up to 50,000.

3. In hospitals of more than 350 beds the Emergency Field Unit should consist of four or more large squads, each headed by a squad leader and capable of functioning, if necessary, as multiple teams. In these large hospitals at least two squads should be on call during each 12-hour period of the day, alternating on first call on alternate days. An Emergency Field Unit of four large squads or two Units of two large squads each, are advisable for a population of 100,000. In large cities, the desirable minimum would be four large squads (16 physicians and assistants) per 100,000.

It will be advisable to organize physicians and nurses engaged in private practice in the area into reserve Emergency Field Units related to hospitals. In areas with small hospitals whose resident staffs cannot be depleted, the primary Emergency Unit of a hospital may be made up in whole or in part of practitioners from the community.

#### RESCUE SQUADS AND STRETCHER TEAMS

Rescue Squads consist of auxiliaries of the police or fire department, who are trained and equipped for clearance and demolition work. Although their function is to extricate the injured, they have also had training in first aid and in stretcher bearing so that each member can serve as the leader of a Stretcher Team. Their first aid services at the time of the disaster should be restricted solely to most urgent needs such as the arrest of profuse bleeding or the application of a leg splint. Their primary object should be to remove the injured as soon as possible from the scene of danger with the aid of Volunteer Stretcher Teams and get them to a First Aid Post or Casualty Station.

Casualties will be conducted on foot or transported on stretchers to the nearest Casualty Station or First Aid Post by Rescue Squads of the police, fire, or other municipal department. These Rescue Squads may be assisted by Air Raid Wardens and by volunteers enlisted at the time. Police and fire reserves should be well trained in first aid and stretcher bearing, and organized into Rescue Squads of four or eight, headed by a squad leader. By

the addition of volunteers, a Rescue Squad is capable of being multiplied into as many stretcher teams as there are members, each trained member becoming the leader of a team.

Provision should be made for the storage of standard stretchers, collapsible cots, and blankets in designated locations, such as police and fire stations, hospitals, health centers, or other suitable place. The number of standard stretchers stored in each police and fire station should be equal to the number of members of the station's Rescue Squads.

It will be advisable to have three times as many collapsible cots or stretchers and two blankets for every stretcher and cot. This equipment should be transported by the truck carrying the Rescue Squad to the site of the Casualty Station or First Aid Post.

#### TRANSPORTATION

A hospital ambulance, station wagon, small truck, or passenger vehicle will be adequate to transport the personnel of a squad and their equipment to the site designated by the local Director of Civilian Defense for the establishment of a Casualty Station. On return trips to the hospital with casualties such vehicle will be available for transportation of additional squads and equipment if required. Hospitals which do not maintain an ambulance service will find it necessary to provide for transportation, utilizing private or municipal ambulance services, small vehicles of the police, fire, or other municipal departments, station wagons, or passenger cars. Special racks can be installed in private ambulances and in station wagons and small trucks so that they may be utilized in an emergency for the transportation of four or more stretcher patients at a time.

Private vehicles recruited for ambulance purposes by the American National Red Cross or other agency should be assigned to a hospital or to a designated parking center under the control of a transport officer.

#### MEDICAL AND SURGICAL SUPPLIES

Supplies for the present must come from local sources. Standard equipment lists are presented in Medical Bulletin No. 2 of the Office of Civilian Defense (now in press). The working supply of each team is best carried in a portable bag, box or haversack, provided with suitable compartments. Provision should be made for a reserve supply of sterile dressings in drums or packs from which the working supplies may be replenished.

## RECORDS

Identification tags should be affixed to the injured by the Rescue Squad or else immediately upon arrival at the Casualty Station or First Aid Post. A duplicate record should be kept in a book which should be standard equipment of each medical emergency team. The record should include the name or other identification, address, person to be notified, diagnosis, first aid administered, morphine if given, and disposition. A form approved by the Medical Division of the Office of Civilian Defense will be found in a supplementary memorandum on equipment. One nurse or nurses' aide should be assigned the responsibility for these records. The forehead of tourniquet cases and of patients urgently requiring priority attention should be marked TK or U, respectively, with a red crayon, skin pencil, or lipstick.

## MUNICIPAL MEDICAL CHIEFS

To expedite the administration of emergency medical services, it is important that a Chief of Emergency Medical Service be appointed without delay for each municipality.

The Chief of Emergency Medical Service should be a physician of recognized professional skill and administrative ability, whose selection should be approved by the local medical society. He should also hold the position of Chairman of the Health and First Aid Committee.

## RESPONSIBILITIES OF LOCAL MEDICAL CHIEFS

Under the administrative authority granted the Director of Civilian Defense, the local Chief of E. M. S. should be responsible for the following functions:

1. To determine the scope and activities of all organizations available for participation in the emergency medical service program. To assist these organizations in the adaptation and expansion of their activities for proper integration in the program.
2. To assist hospital authorities and physicians in organizing, equipping and training Emergency Medical Field Units.
3. To formulate a workable plan, integrated with other phases of civilian defense, by which prompt and adequate medical care may be provided during any emergency.
4. To make a "spot" map for the information of all concerned, indicating the hospitals and emergency Medical Field Units, sites of Casualty Stations, sites of depots or other sources where medical supplies are available, and the location of rescue squads. The map should indicate lines of evacuation

and location of neighboring municipalities within a fifty-mile radius coöperating in evacuation, indicating facilities in such municipalities.

Copies of the map should be furnished to Control Centers, Police and Fire Departments, State Police Headquarters, local Health Departments, local Red Cross Chapter, State Defense Council, Regional Medical Officer and all coöperating hospitals.

5. To organize adequate transportation services for casualties and medical personnel, by a coöperative agreement between local government departments, American Red Cross and other voluntary agencies. These services should be capable of executing an evacuation problem involving hospital facilities in neighboring municipalities.

6. To assist in establishing Red Cross classes for instruction in First Aid and Nurses' Aid. To assist Red Cross placement bureaux in placing Nurses' Aids in hospitals, clinics, health department and field nursing service to continue their training after completion of initial courses.

7. To promote the training and organization of effective First Aid Detachments among the employees of industrial plants and business establishments.

8. To collaborate with the health departments in a program for the protection of the community against emergency sanitary hazards.

9. To collaborate with State Defense Councils and other authorities in preparing plans for evacuation of the general population, with particular reference to rendering adequate medical care under such circumstances.

10. To keep the community, voluntary agencies, and particularly the medical profession informed of the activities of Emergency Medical Services.

In general, the Chief of Emergency Medical Service will be expected to integrate all local medical and hospital resources into a comprehensive program for civilian protection. He should be assisted and advised by the Committee on Health and First Aid. See next paragraph.

## HEALTH AND FIRST-AID COMMITTEE

The Municipal Committee on Health and First Aid is charged with the responsibility of developing and promoting a Health and First Aid Program as approved by the Local Defense Council.

The personnel of the committee should include physicians, dentists, nurses, pharmacists and laymen familiar with health and first aid problems. It is recommended that the chairman of the committee be a physician, respected for his professional attainments and administrative ability.

The program of the committee, as approved by the Municipal Defense Council and as adapted to the needs of the community, should



be based upon the findings of a community survey to determine:

1. Existing facilities and needs which may be required to maintain and promote health, and provide medical care in the community.
2. The available number of physicians and nurses, and the proposed function of each in the program.
3. The existing hospital facilities.
4. The degree of expansion of present hospital facilities to meet the demands of an emergency.<sup>2</sup>
5. The available space which might be adapted to installation of emergency hospitals, such as found in schools, churches, and other public buildings; and the sites which might be adaptable to First Aid or Casualty Stations.
6. The available quantities of medical supplies and the sources from which additional supplies may be promptly obtained. Such supplies should include blankets, pillows, pillow cases, cots, hot-water bottles, dressings, drugs, serum, etc.
7. The space and accommodations which may be utilized to care for and feed evacuees transported from other communities.
8. The number of volunteers to assist in carrying out a program and the proper function for which each individual is best adapted.

Concurrent with the above effort, classes should be organized for the purpose of receiving First Aid and Nurses' Aid instruction. Such classes should be conducted under the supervision of a Red Cross Chapter, instructed by qualified Red Cross instructors following the content of the Red Cross First

Aid Manual. It is hoped that 10 per cent of the population will receive such instruction. See page 15 of this *Journal*.

Instructions relative to the carrying out of details involved in other parts of the program of this committee will be issued from this headquarters from time to time, or upon request received from the Municipal Defense Council.

#### STATE DEFENSE AREAS

Branch offices of the New Jersey Defense Council will be located as follows:

*Jersey City:* Counties of Hudson, Bergen and Passaic. DR. SAMUEL A. COSGROVE of Jersey City will be the medical chief for this area.

*Morristown:* Counties of Essex, Morris, Warren and Sussex. DR. BERNARD C. McMAHON of Morristown will be the medical chief for this area.

*New Brunswick:* Counties of Union, Somerset, Middlesex, Mercer and Hunterdon. DR. ROBERT L. MCKIERNAN of New Brunswick will be the medical chief for this area.

*Asbury Park:* Counties of Cape May, Atlantic, Ocean and Monmouth. DR. ROBERT A. KILDUFFE of Atlantic City will be the medical chief for this area.

*Camden:* Counties of Camden, Burlington, Salem, Gloucester and Cumberland. DR. HENRY B. DECKER of Camden will be the medical chief for this area.

## THE HOSPITAL IN CIVILIAN DEFENSE \*

H. VAN ZILE HYDE, M.D.

Regional Medical Officer, Second Civilian Defense Region, United States Office of Civilian Defense

The sudden advent of war, bringing with it a real threat to the civilian population of the United States, has impressed the hospitals of the country with the grave responsibilities they carry in relation to the protection of the public under attack from the air. Problems relating to blackout, protection of buildings and organization of emergency services, which seemed academic on December 6, were catapulted over that week-end to a status of immediate concern to every hospital administrator and to every physician.

The hospital must integrate its services into the civilian defense mechanism of the community which it serves, assume responsibility

for the proper protection of its own property; serve as a training center and develop effective internal organization for the handling of casualties.

#### INTEGRATION WITH CIVILIAN DEFENSE ORGANIZATION

In order that casualties occurring unexpectedly, often in large numbers and under chaotic conditions, may be promptly and properly handled with a minimum loss of life, hospitals must fit in with the complex mechanism which is being set up in all communities for the prompt delivery of necessary services to points of disaster. This mechanism consists of a sys-

2. The term "Emergency Expansion" indicates the expansion possible by discharge of convalescent patients and utilization of corridors, clinic rooms, consultation rooms, nurses' homes, etc.

\*Taken, with permission, from a similar article in the *New York State Journal of Medicine* for Jan. 1, 1942, and adapted for *New Jersey* by Dr. Schlichter and Dr. Scott.



tem of control centers, each control center providing services for a district. In each control center there will be a civilian defense director or commander. With him there will be individuals responsible to him for each of the essential emergency services. In the control center a "medical adjutant" will be responsible for the proper deployment of emergency medical field units, the establishment of casualty stations,<sup>3</sup> first aid posts and other medical emergency facilities. He will also keep the transport officer in the control center advised as to the need for ambulances and other transportation facilities required for the casualty services within the area. He will keep informed as to the number of available beds in the hospitals in the control area and will route casualties accordingly.

In large cities it will be necessary to have a main control center, with all the emergency facilities of the city at its disposal, in order to mobilize support for the control areas whose facilities are strained beyond their capacities. The main control center will, when set up and in operation, keep informed through the District Control Centers of the daily census of hospital beds available in all districts of the area and the status of all Emergency Medical Field Units and of all ambulances and other vehicles available in the various districts.

This control mechanism is being set up by the defense councils. To organize the casualty services, which are an essential part of the emergency services provided by the control mechanism, Chiefs of Emergency Medical Service have been appointed on a municipal and regional basis according to the laws of New Jersey. They are preparing spot maps for use in the control centers. These maps show the size and location of hospitals, the sites where casualty stations can be set up, the size and location of emergency medical field units and other information necessary for the proper functioning of the medical adjutant in the control center.

Through the Municipal Chief<sup>4</sup> of Emergency Medical Service, each hospital can determine how it fits into the general plan of emergency service in its community and surrounding area. As a basic necessity, every hospital has been urgently requested to form, drill and equip emergency medical field units as described in Bulletin Number 1 of the Medical Division of the Office of Civilian Defense as adopted by the New Jersey Defense Council to fit the needs of the State. These units are the tools with which the medical adjutant must work in providing effective service to the public.

Information concerning details of the organization of Emergency Medical Service in New Jersey will be found on page 9 of this *Journal*.

#### PROTECTION OF HOSPITAL PROPERTY

Complete protection of property against damage from enemy air attack is impossible. Certain important measures can be taken, however, to ward off attack and to limit damage caused by attack. The extent to which these measures are carried out by any hospital must depend upon the strategic importance of the area in which it is located, the structural characteristics of the building, the resources of the hospital and the foresight of its management. Working with the American Hospital Association, the Medical Division of the Office of Civilian Defense has prepared Bulletin No. 3, "*Air Raid Protection of Hospitals*". A tentative draft, prepared through the courtesy of the Hospital Council of Greater New York, has been distributed to the hospitals of this State by the New Jersey Defense Council. Using this in conjunction with "*Blackouts*" and "*Glass and Glass Substitutes*", published by the United States Office of Civilian Defense, hospital administrators are in a position to proceed according to the requirements of their own areas. The matters to be taken under immediate consideration are:

1. Preparation for blackout, so that hospital may continue essential services and handle casualties under blackout conditions.
2. Protection of personnel from flying glass.
3. Fire protection with particular reference to control of incendiary bombs.
4. Protection and clearance of basement. Establishment of basement operating rooms.
5. Mapping of utilities and provision for sectional control and auxiliary service.
6. Clearance and fireproofing of attic and provision of accessible entrances to attic and roof.
7. Provision of reserve stocks—beds, blankets, food, fuel, drugs and biologicals, surgical dressings, etc.

#### THE HOSPITAL AS A TRAINING CENTER

As a training center the hospital serves a vital rôle in the civilian defense program. It alone can train nurses and nurses' aides.

Hospitals are aware of the present shortage of trained nurses. It is essential, for the protection of the public, that training schools step up their production to the full limit of their resources. A recent rapid survey by the New York Health Preparedness Commission showed that approximately ten per cent of available hospital nursing staff positions were unfilled, due to inability of administrators to obtain

3. See page 9 of this *Journal*.

4. See page 11 of this *Journal*.

qualified nurses. This was the state of affairs before the United States became involved in the war.

It is appreciated that present needs cannot be met, or even partly met with the speed now necessary, by accelerating the training of full-fledged nurses. For this reason the Office of Civilian Defense and the Red Cross have launched a program for the training of 100,000 volunteer nurses' aides: pinch-hitters for war-time America.

Strict standards of selection of volunteers, intensive training, and a probationary extramural period are required to protect hospitals from defense dilettanti. Nurses' aides, working always under trained nurses, can carry a significant share of the hospital nursing load and can play an important community rôle by assisting in school, industrial, public health and visiting nurse services. During enemy air attack they would be essential for the proper functioning of casualty stations and first aid posts to which they would be attached.

#### INTERNAL ORGANIZATION

So that smooth and efficient operation may be maintained under any conditions, plans must be made now for the reception of casualties. This must include plans for efficient distribution and routing of casualties to treatment, fracture and operating rooms, and to wards. Provision should be made for expansion of all of these facilities. Surgical teams, general and special, should be organized. The New Jersey State Chief of Emergency Medical Service recommends that minimum organization demands formation of general surgical, head and unscrubbed fracture teams in all hospitals. Essential non-professional as well as professional personnel, should be placed on call and priority of call established.

It is time now for hospitals to prepare themselves for any eventuality. No one knows whether the United States will be bombed. All that is known is that there are tremendous forces anxious to destroy our cities and our people. That should be enough to stimulate action now.

Hospitals should familiarize themselves with the following publications:

a. Medical Division Bulletin No. 1, U. S. Office Civilian Defense—*"Emergency Medical Service for Civilian Defense"*, as altered to meet the needs of New Jersey and distributed

to all New Jersey hospitals by the New Jersey Defense Council. This Bulletin contains details of the organization of the Emergency Medical Units.

b. Medical Division Bulletin No. 2, U. S. Office Civilian Defense—*"Equipment and Operation of Emergency Medical Field Units"*.

c. Medical Division Bulletin No. 3, U. S. Office Civilian Defense—*"Air Raid Protection of Hospitals"*. This Bulletin discusses many administrative and protection problems.

#### STATEMENT OF N. J. HOSPITALS

In order to clarify the definite responsibilities of hospitals to their communities and to the official program of the New Jersey Defense Council, the following statement is made by the New Jersey Hospital Association:

1. Each municipality is responsible for its own safety and welfare to the limit of its facilities.

2. Each municipality has a Local Defense Council responsible under the law for the proper formulation and execution of the municipal defense program.

3. Each municipal council has a "Health and First Aid Committee" whose duty is to formulate and execute plans to guard the health and provide medical care for the citizens of that municipality.

4. The plans formulated by the "Health and First Aid Committee" and approved by the Municipal Defense Council will be initiated and administered by the Chief of Emergency Medical Service for that municipality. This officer is a physician and a member of the "Health and First Aid Committee". He is appointed by the Chairman of the Municipal Defense Council.

5. When necessary, local medical facilities in any municipality will be supplemented by the facilities of neighboring municipalities on a regional basis through regional offices of the New Jersey Defense Council. This will be accomplished by Regional Deputy Chiefs of Emergency Medical Service under the direction of the Chief of Emergency Medical Service of the New Jersey State Defense Council.

6. The hospital will look to its Municipal Chief of Emergency Medical Service for instruction. If the Chief of Emergency Medical Service in your municipality has not yet been appointed, or if the hospital is not situated within the limits of a municipality, the hospital will make contact with the Regional Chief of Emergency Medical Service.

7. All municipal medical plans as well as other phases of the Defense Program will be adopted only after approval by the Municipal Defense Councils.

8. The above organization principles are approved and promulgated by the New Jersey Defense Council.



## PHYSICIANS WANTED AS INSTRUCTORS

The Red Cross is now prepared to offer First Aid courses for Civilian Defense. There are two of these courses, a Standard course of 20 hours and an Advanced course of 10 hours. They are comparable to the First Aid courses regularly offered by the Red Cross, but with emphasis on conditions to which civilians may be subject in war time. More attention is paid to skills in control of bleeding, in caring for wounds and fractures and to transportation. There is extra material on war gases.

First Aid Instructors holding active Red Cross appointments are authorized to teach these courses. The subject matter in the *Red Cross First Aid Textbook* and a supplement on war gases provided to accompany the textbook will form the basis for all instruction. The customary Red Cross First Aid certificates will be issued, provided the student holds an active Red Cross Standard or Advanced certificate.

*Instructor's Outline—First Aid Course for Civilian Defense* (ARC-1055) and *Advanced First Aid for Civilian Defense* (ARC-1056) set forth in detail the material to be taught and the order for presentation for each course. These Outlines should be secured immediately from the Red Cross Area office by the Chapters for the use of First Aid Instructors who will teach Civilian Defense groups. The instructors should acquaint themselves completely with the contents.

It should be noted in respect to Advanced First Aid for Civilian Defense that this 10-hour course is intended for the supplementary instruction of all members of Emergency Medical Field Units, and for nursing auxiliaries and members of other Civilian Defense Units who have had previous instruction.

It is requested that Chiefs of Emergency Medical Service give whole-hearted support in coöperating with American Red Cross Chapters, and that they expedite the organization of First Aid classes. If it should arise that some members of the Civilian Defense classes are unable to pay for the American Red Cross textbook, arrangements will be made with the American Red Cross for the loan of the textbook. Inability to purchase a textbook should not prevent any person from securing such training. You will receive willing coöperation of the American Red Cross Chapters in this matter.

We wish to advise that these courses are now available and that no time should be lost in getting instruction under way. First Aid training is an all-important element in the preparation for Civilian Defense.

Physicians willing to serve in this capacity should apply immediately to the nearest Red Cross Chapter. A list of such chapters follows:

Atlantic City—405 City Hall Annex, Mrs. Somers  
Bayonne—697 Avenue C, Miss Capitain  
Belleville—34 Rossmore Place, Miss Adams  
Belvidere—202 Mansfield Street, Dr. Cummins  
Beverly—103 East Warren Street, Mrs. McCarthy  
Blairstown—Care of Mrs. W. R. Bostwick  
Bloomfield—6 Washington Street, Mrs. Pinnigan  
Bound Brook—417 East Main Street, Mrs. Blanton  
Branchville—Care of Douglas Roy  
Bridgeton—10 W. Commerce Street, Miss Sheppard  
Burlington—Mr. Gerry Yentzer  
Caldwell—188 Smull Avenue, Mrs. L. B. Caziarc  
Camden—Court House, Miss Williams  
Cape May—Court House, Mrs. Watson  
Clifton—795 Main Street, Mrs. Dobson  
Cranford—308 Prospect Avenue, Mr. Whipple  
Dover—13 South Sussex Avenue, Mr. Hartley  
East Rutherford—26 Lincoln Place, Miss Kaufman  
Elizabeth—1073 East Jersey Street, Mrs. Hansen  
Flemington—Hall of Records, Mrs. C. Rymen Herr  
Fort Lee—1635 Parker Avenue, Mrs. Vogel  
Glen Ridge—391 Forest Avenue, Mr. Salt  
Hackensack—360 State Street, Mrs. Barney  
Hackettstown—313 Sharpe Street, Mrs. Vliet  
Hoboken—37 Newark Street, Mrs. McCarthy  
Irvington—22 Silkman Place, Mrs. A. E. Braun  
Jersey City—711 Bergen Avenue, Miss James  
Madison—25 Cooke Avenue, Mrs. Marshall  
Mansville—74 South Main Street, Mr. Onka  
Metuchen—159 Lake Avenue, Major Giger  
Millville—318 North High Street, Mr. Chubb  
Montclair—446 Bloomfield Avenue, Miss Farrell  
Morristown—10 Park Place, Mrs. Farley  
Newark—710 High Street, Mr. Gordon Stone  
New Brunswick—417 George Street  
Oranges—232 South Harrison Street  
Passaic—128 Passaic Avenue, Mrs. Tauber  
Paterson—232 Market Street, Mr. Brooks  
Perth Amboy—280 Hobart Street, Miss Clapham  
Phillipsburg—Municipal Building, Mrs. C. R. Weisel  
Plainfield—202 West Seventh Street, Mrs. Miner  
Princeton—69 Palmer Square, Mrs. Laughlin  
Rahway—1470 Campbell Street, Miss Armstrong  
Ramsey—Care of Mr. Dwight P. Little  
Red Bank—107 Monmouth Street, Miss Tompkins  
Ridgewood—235 E. Ridgewood Avenue, Mr. Stout  
Rutherford—79 Donaldson Avenue, Miss Forde  
Salem—Mrs. Robert F. Laird, Grant Avenue  
Somerset—20 Claremont Road, Miss Cunningham  
Somerville—58 West Cliff Street, Mr. Adams  
South Amboy—312 Main Street, Mrs. Dillon  
Springfield—Mrs. F. C. Geiger, Municipal Building  
Summit—69 Woodland Avenue, Mrs. Card  
Trenton—Miss McPetridge, Room 314, Post-Office  
Vineland—Mrs. Thomas Ramsey, East Park Avenue  
Washington—151 Belvidere Avenue, Mrs. Yard  
Westfield—37 Elm Street, Mr. Plumridge  
Westwood—77 Jefferson Avenue, Mr. Wallace  
Woodbridge—569 Rahway Avenue, Mrs. Randolph  
Woodbury—Mrs. W. T. Furey, P. O. Box No. 592

## THE MEDICAL SOCIETY IN THE DEFENSE PROGRAM

The mayor of each municipality, assisted by his Local Defense Council, is responsible for a defense program for his community. No other person or other organization is responsible.

All phases of local defense, including its medical program, must be approved by the Local Defense Council. All appointments of personnel involved in the program must be made by the mayor through the Local Defense Council. This is in accordance with the New Jersey laws.

Voluntary organizations, such as Medical Societies, do not enter the defense program as entities. Voluntary organizations have certain facilities and specially trained personnel among their members, who, as individuals, will play important parts in the program. They do this as individual citizens, and not as organizations. Voluntary organizations do not have official or appointive powers.

The key position in the medical phase of the defense program is the Office of Chief of Emergency Medical Service in each municipality. This office, occupied by a physician, will be responsible for the initiation and administration of medical plans to guard the health

and provide medical care for the people as approved by the Local Defense Council.

Local medical facilities and personnel will be supplemented when necessary by the facilities of neighboring municipalities. Such additional facilities will be integrated and coordinated through the Regional and State Offices of the New Jersey Defense Council.

Medical Societies may be of assistance in the Civil Defense Program now by:

1. Supporting as an organization the policy of the New Jersey Defense Council.
2. Offering the services of their members to each Local Defense Council for such services as they may be able to render the Local Councils in their program.
3. Promoting the first aid program by offering their services as individuals to their local Red Cross Chapters as first aid instructors. (See page 15.)
4. Participating in the advanced course of instruction to qualify themselves as instructors to lay groups in the Red Cross program.
5. Promoting the organization of Emergency Medical Field Units in their respective hospitals.
6. Promoting the organization of nurses' aid classes in their respective hospitals.

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## THE PHARMACY AND CIVILIAN DEFENSE

The following recommendations have been made by the Medical Division of the U. S. Office of Civilian Defense:

(A) Large amounts of glass and space limitations make pharmacies unsuitable sites for Casualty Stations and First Aid Posts.

(B) Pharmacies are readily accessible in every community, are open during the greater part of the day and evening and are visited frequently by members of the community. They are admirable sites for the dissemination of information.

(C) The stock of drugs, medicines, surgical and sick room supplies available for purchase in every pharmacy should be kept constantly replenished.

(D) Each pharmacist should:

1. Register with the Chief of Emergency Medical Service in his community, indicating the supplies he has available.

2. Register his delivery truck for emergency use, by listing it with the transport officer of the local Defense Corps.

3. Register his pharmacy with the air raid warden, indicating the telephone and refuge facilities he has available.

4. Place his services at the disposal of the Local Defense Council for distributing hand bills, displaying placards, and other information on Civilian Defense.

5. Inform himself of the organization, location and character of protection facilities in his neighborhood so that he can direct citizens to shelters, wardens' posts, casualty stations and first aid posts.

6. Review and extend his own training in first aid and prepare himself to instruct others in his employ.

7. Large pharmacies should establish a First Aid Detachment among their employees which can be immediately available as a stretcher team to assist the Rescue Squads in the extrication of casualties from demolished buildings and transport them to the First Aid Posts of the Emergency Medical Service. For this purpose, it is advisable that pharmacies be



equipped with stretchers and with first aid supplies.

8. It is important that pharmacies avoid the use of any Civilian Defense designation which would tend to confuse the public concerning the location of Casualty Stations and First Aid

Posts of the Emergency Medical Service. Injured persons should obtain care at official stations of the Emergency Medical Service or from their private physicians.

GEORGE BAEHR, M.D.,

Chief Medical Officer, Office of Civilian Defense.

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## NURSES NEEDED TO TEACH RED CROSS NURSING

Nurses are stepping in line by enrolling as Red Cross first reserves to take their places with the Army or Navy. Private citizens are receiving training as volunteer nurse's aides, to help in hospitals and clinics. And now comes a great demand from homemakers and schools for classes in Red Cross Home Nursing. With an estimated 500,000 persons requesting this instruction, where are the nurse-instructors to conduct the classes?

Three hundred thousand members of the nursing profession answered the questionnaires sent out during the recently conducted Survey of Nurses. The number who taught Red Cross Home Nursing classes last year was less than one per cent of this figure. Furthermore, there are many trained nurses, who because of marriage or for other reasons are no longer active but who would make ideal instructors coöperating with their local Red Cross chapter or branch.

Upon this vast reservoir of hundreds of thousands of trained nurses the Red Cross is relying to secure enough instructors to meet the needs of the growing enrollment of students in Red Cross Home Nursing classes.

The standard course in this subject requires 24 hours of classroom work using the Red Cross textbook. For the teacher's assistance, a Guide for Instructors is provided as well as special materials for classroom use. Classes

generally are given in two-hour sessions, twice a week, and, as there is always a demand for morning, afternoon and evening classes, the time can be arranged to suit the instructor.

Some nurses may hesitate because they cannot easily get away from home and the children or because of other reasons. Often arrangements can be made through neighbors or other interested groups for the care of the instructor's children during class periods. Local Red Cross chapters also expect to carry the cost of the course. In fact, every effort will be made to help the nurse who feels she is in a position to devote four hours or more a week to her Red Cross chapter and community for a period of six weeks.

Here is a far-reaching opportunity to make a valuable contribution to national defense. The women and girls enrolled in the Red Cross Home Nursing course, learning to safeguard their own families and homes, will be building a bulwark of strength in their own communities. Defense of the home is the core of national defense. The nurse who volunteers her services as instructor is the vitalizing force which sets in motion this vast program of home preparedness. Nurses are urged to take advantage of this opportunity and get in touch immediately with their local Red Cross Chapter or Branch.

A list of Red Cross Chapters will be found on page 15 of this *Journal*.

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## NEW MEDICAL DIVISION EXECUTIVE

Mrs. Meta Neumann of Fanwood has been appointed as an executive to assist in the administration of the Medical Division of the New Jersey Defense Council. Additional assistance has been rendered necessary by the rapid overload of the work in that office. Mrs. Neuman has given up her position as editor of a hospital and nursing journal to enter the Civilian Defense program.

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## CHEMICAL WARFARE INSTRUCTION

Dr. R. A. Kilduffe of Atlantic City and Dr. Arturo Casilli of Elizabeth will attend the Chemical Warfare School at Edgewood Arsenal for a special course of instruction on "Gas Warfare and Defense" as representatives of the New Jersey Defense Council.

## MENTAL DISEASE IN THE ARMY

The incidence of mental disease among selectees inducted into the Army has been so much discussed that the following statement from the Surgeon-General is considered especially timely:

Our estimate, based on experience up to July, 1941, is that three out of every thousand men in the Army will be discharged annually because of mental disability. Only one-sixth of these, however, will be from among men inducted through Selective Service. Our study shows approximately the following ratio: Selective Service—1, to National Guard—2, to Regular Army—3. (That is 17 per cent from selectees, 33 per cent from National Guardsmen, and 50 per cent from the Regular Army).

Of men discharged for mental disability, half will be sent home or to state institutions; 34 per cent will be cared for by the Veterans' Bureau; and 16 per cent by St. Elizabeth's Hospital.

Our returns show that about 350 out of 1½ million men are admitted weekly for mental observation. Many of these, of course, are re-

turned to duty, some are discharged for inaptitude and similar reasons; and the rest go to an Army General Hospital for further observation. These general hospitals have some 2000 beds occupied by such cases: the observation period run from 50 to 120 days.

These figures will give a fair idea of the picture up to last summer. Recent developments may produce some changes, and the screening now done by Selective Service doctors\* and Army Boards should lower considerably the number of mental defectives and mental disorders among men being inducted.

*Note: The discovery that 3 out of a thousand, or 0.3 per cent of the men suffer mental breakdowns does not mean that the draft boards and induction boards made a diagnostic error of three-tenths of one per cent in the psychiatric examinations, since presumably many of these casualties were undetectable by any means prior to service. Even if all the psychiatric casualties could be charged to diagnostic errors, an error-incidence of three-tenths of one per cent strikes us as a record as good as any that doctors can expect even in the most leisurely studies available in civilian practice.—Editor*

## MEDICAL PROCUREMENT AND THE A. M. A.

At the Annual Session of the American Medical Association in June, 1941, the Committee on Medical Preparedness brought to the House of Delegates a resolution urging the establishment of a Procurement and Assignment Agency, which would enable the government to select more promptly and more wisely those physicians necessary for military, civilian and industrial service.

Subsequently this resolution was endorsed by the Health and Medical Committee, which has been assigned to the Coördinator for Health, Welfare and Related Activities.

In all the warring nations the problem of medical personnel is prominent. Articles in British journals reflect the difficulty of maintaining in Great Britain the social medical system of supplying industries with the physicians required and of giving medical attention to the Army, the Navy, the Royal Air Force and the civilian defense groups. A note from Germany indicates that because of the depletion of the medical profession by emigration and the needs of the military services there are now some

areas in which there is available only one physician to every 4,500 people.

Consider, too, that the need for medical personnel includes not only the supplying of the Medical Corps of the Army and Navy, but also the procurement of physicians for the Public Health Service, the Red Cross, the Marines, the Coast Guard, the draft boards, the appeal boards, the Veterans' Administration, civilian defense agencies and defense-busy industrial plants.

Already it is apparent that the procurement and assignment of physicians in the United States for some of the innumerable calls which are likely to be made on them in the near future represents a task that will take the best available information and organizational ability.

The American Medical Association has available on a punch-card system the names of more than 160,000 American physicians licensed to practice, with complete information regarding their ability and availability for many different types of medical service.

More than 95 per cent of the physicians who answered the A. M. A. questionnaire indicated their willingness to serve their country when needed.

\* In this connection, readers are referred to an article describing this screening process which appeared on page 398 of the August 1941 issue of this *Journal*. The paper, by Dr. Theodore Robie of Montclair, was aptly entitled "The Draft Board and Physician's Responsibility".

# ORIGINAL ARTICLES

## ERYTHREMIC RESPONSE TO LIVER THERAPY IN TREATMENT OF PERNICIOUS ANEMIA

By PAUL B. FERRARY, M.D., Totowa, N. J.

An interesting and unusual complication in the course of liver therapy for pernicious anemia is presented here.

The production of an erythremic blood picture in a pernicious anemia patient by the use of liver extract given parenterally in moderate dosage is rare enough to warrant this report. A search of the Surgeon General's Index and recent copies of the Quarterly Cumulative Index Medicus did not produce a similar report.

Case No. 29192. Mrs. M. M., a 64-year-old housewife, referred by Dr. H. D. Bongiorno, was admitted to the medical outpatient department on July 26, 1939, for continuation of treatment for pernicious anemia.

On January 13, 1934, she consulted her family physician because of weakness and nausea. At that time the blood count was: Hb 40 per cent, RBC 1,600,000, color index 1.20, marked anisocytosis and poikilocytosis, WBC 5,200, lymphocytes 45 per cent, polymorphonuclear neutrophils 55 per cent. Intramuscular injections of liver extract were begun with resultant improvement, but she neglected treatment and reported only intermittently.

### HISTORY

The history then obtained was one of progressive weakness for several months, mainly weakness of the lower extremities, unsteady gait, and twitching. Nausea and vomiting had been present for several weeks. She also complained of cardiac palpitation and dyspnea on slight exertion with some edema of the ankles since the onset of her illness. Nocturnal urinary frequency was five times.

### FINDINGS

Examination revealed an elderly white woman with a lemon-yellow tint to the skin. The sclerae were icteric, the tongue smooth

and inflamed. A soft systolic murmur was heard at the apex of the heart. Hb. 45 per cent, RBC 1,610,000, color index 1.39. Moderate anisocytosis and poikilocytosis. Polychromatophilia was present. Macrocytes predominated in the blood smear, and there were 4 per cent normoblasts and 6 per cent reticulocytes. The urine showed traces of sugar and albumin, moderate pus and occasional blood cells. The fasting blood sugar was 200 mg. per 100 cc.

### COURSE

Diagnosis of pernicious anemia and diabetes mellitus was made, and daily intramuscular injections of 2 cc. concentrated liver extract were begun on April 29 and continued to May 23, when the frequency was reduced to twice weekly. Repeated urinalyses showed no sugar and on May 16 the blood sugar was 108 mg. per 100 cc. She was discharged on May 31. The blood count at that time showed: Hb. 60 per cent, RBC 3,650,000, color index 0.82.

Treatment at home was more regular than formerly, and when the patient was admitted to the outpatient department her blood count on July 28, 1939, showed Hb. 86 per cent, RBC 4,280,000, color index 1.00, red cells showed normal appearance. Intramuscular liver injections of 10 USP units were given weekly.

### DEVELOPMENT OF ERYTHREMIA

Between September, 1939, and May, 1940, the hemoglobin ranged from 90 to 108 per cent, and the red count from 4,520,000 to 6,640,000. The highest values were recorded in November and the lowest in May. Since September 17, 1939, the liver dosage had been 10 USP units every two weeks.

No blood count was done from May, 1940, to October 27, 1940, when the hemoglobin was 131 per cent and the erythrocytes were 10,650,-



000 per cu. mm. The administration of liver extract was discontinued, and on November 6, 1940, the hemoglobin was 120 per cent and the erythrocytes 6,250,000, and by December 3, 1940, the hemoglobin had fallen to 86 per cent and the erythrocytes to 4,640,000.

#### RECENT COURSE

In December, 1940, the patient complained of dysuria and the urine showed four-plus sugar. Blood sugar was 362 mg/100 cc. The usual routine urinalysis had been overlooked and her hospital record had not been consulted up to this time, hence the late discovery of the diabetes. This has been well controlled by dietary measures alone.

Liver extract was resumed on December 18, 1940, in dosage of 10 units every three weeks. The blood count has been normal; the latest on July 11, 1941, showed Hb 100 per cent, RBC 5,050,000.

#### COMMENT

Adamson and Storey<sup>1</sup> assert that the intrinsic factor lacking in pernicious anemia exists in excess in polycythemia vera. This suggests that these disorders are physiologic opposites. They have been able to produce relative erythremia in rats by the injection of normal gastric juice.

By inference, it might be thought that excessive quantities of the liver fraction used in the treatment of pernicious anemia could provoke the same phenomenon, but Gingold<sup>2</sup> was able to produce only moderate erythrocyte increase (to 6,080,000 per cmm.) by daily large intramuscular doses of liver extract in normal rabbits over a prolonged period.

Geriola<sup>3</sup> reports one case of splenomegalic perniciosiform anemia in which there was an erythremic response to liver therapy.

In the case presented here, several explanations of the phenomenon present themselves:

(1) The liver extract may have been continued through a period of spontaneous remission. This is probably what happened. The same dosage at an earlier period had allowed wide fluctuations in the hemoglobin and erythrocyte values. (2) The patient's hematopoietic response may have been overstimulated by a relative overdosage of liver extract. This is less likely for the reason stated above, for while counts of over six million were obtained on this dosage, subsequent counts did not show a tendency to increase, but rather to decrease; and (3) perhaps the concurrent diabetes produced the erythremic counts by dehydration and hemoconcentration. This explanation is hardly likely because relative erythremic counts do not reach the level attained here, and there were no complaints of diabetic symptoms suggesting dehydration.

We have not attempted to repeat this response because of the manifest dangers of erythremia. The erythrocyte level has been satisfactory on the present reduced dosage, but it is not felt that the erythremic blood picture could be achieved again without the assistance of a spontaneous remission.

#### SUMMARY

1. A 64-year-old woman under treatment for pernicious anemia for six years and nine months was found to have a transient erythremic blood picture.

2. It is felt that this was occasioned by the continuance of liver therapy through a period of spontaneous remission, even though the dosage was relatively small.

3. There was a concurrent diabetes mellitus.

*Editor's Note: Dr. Ferrary's case appears to be unique. At least, the author has found no report in the literature of any instance of erythremia developing from liver therapy. Readers who have knowledge or experience of any such reactions are urged to inform The Journal.*

1. Adamson, W. B., and Storey, J. E.: *Texas Med. Journ.*, 36:26 (May, 1940).

2. Gingold, N.: *Sang. (Paris)*, 13:312 (1939).

3. Geriola, F.: *Bull. Accad. Med. Genova*, 54:890. (Nov., 1939.)



## ANO-RECTAL PAIN, ITS CAUSES AND TREATMENT\*

By JULIUS GERENDASY, M.D., Elizabeth, N. J.

In ano-rectal diseases, pain is the commonest symptom for which relief is sought. It may vary from a burning discomfort to a most agonizing pain.

The correct diagnosis requires a careful history, a general physical examination, and a painstaking proctosigmoidoscopic examination. An understanding of the ano-rectal anatomy is also essential.

Painful sensations are carried from the affected organs or tissues, through peripheral nerves, to ganglia in the spinal cord and to the brain. The peripheral nervous system consists of a cerebro-spinal and a sympathetic part. The degree of pain sensation varies with the individual, and is influenced by the pain sensitivity and the general physical condition of the patient.

### NERVE SUPPLY

In order that the various expressions in the intensity of ano-rectal pain may be understood, a brief review of the nerve supply to the ano-rectal region is necessary. The anus and anal canal and an area of about one cm. above the muco-cutaneous junction are liberally supplied with sensory nerves. The nerve supply of this area is derived chiefly from the third and fourth sacral nerves, and the hemorrhoidal branch of the pudic nerve. The nerve filaments enter the gut at the level of the dentate line. As a result of this sensory nerve supply, certain lesions present at or below this line produce intense pain.

The rectum, in common with the rest of the alimentary tract above the muco-cutaneous junction, is supplied largely from the sympathetic nervous system. It also receives some nerves from the sacral plexus. However, while the mucosa of the rectum above this line becomes progressively less sensitive to prostatic pain, the sensation to distention or pressure tension (pulling or stretching) remains.

Lesions above the muco-cutaneous junction are not productive of painful sensations until they are well advanced, and involve the deeper peri-rectal tissues and nerves or produce stenosis.

If the facts on pain sensitivity mentioned in the above paragraphs were the common knowledge of the medical profession, the result would be less suffering and earlier diagnosis of patients with diseases of the anus and rectum.

### CLASSIFICATION

A classification of ano-rectal pain based on etiology is as follows:

#### A. Anal Pain:

1. Thrombosed hemorrhoids (anal or external).
2. Fissure.
3. Cryptitis.
4. Papillitis.
5. Subsphincteric (crypt) abscess.
6. Inflammatory ulcerated prolapsed hemorrhoids or mucosa.
7. Strangulated prolapsed internal hemorrhoids.

#### B. Para Rectal Pain:

1. Abscess  
Perianal (marginal).  
Ischiorectal.

#### C. High Rectal Pain:

1. Ulcerative procto-colitis.
2. Lymphopathia venerea.
3. Functional spasm of the levator muscles.
4. Submucosal abscess.
5. Superior rectal space abscess.
6. Carcinoma ulcerated or infiltrating.
7. Prostatic abscess or malignancy.

#### D. Coccygodynia:

1. Spasm of coccygeus muscles.
2. Bursitis of levator ani muscles and pubo-rectalis bursae.
3. Fracture or dislocation of coccyx.

\* Read before the Section on Gastro-enterology of the Annual Meeting of The Medical Society of New Jersey in Atlantic City, June 5, 1940.

## TAKING THE HISTORY

In eliciting the symptoms which these lesions produce, too much reliance should not be placed on the patient's knowledge of ano-rectal anatomy, or of his medical terminology. A detailed *history* in chronologic order must be taken. This should include both local and remote organs. It should be determined whether the pain is due to disease in the anal canal, high up in the rectum, or in organs proximal to these. Also whether it is constant or intermittent. One should ask if the pain occurs before or after defecation, and whether this is followed by relief or aggravation of symptoms. For example, constant pain suggests anal ulcer or cryptitis. A sense of incomplete defecation and tenesmus suggests malignancy of the terminal bowel. It should be noted that pain in the ano-rectum may arise reflexly from disease of the G.-U. tract in the male, or pelvic organs in the female.

Because the anal tissues above and below the muco-cutaneous junction are rich in sensory nerve endings, pain sensation in this area is sometimes out of proportion to the size of the lesion. This extreme sensitiveness will often suggest the location of the lesion,—that is, the anus. Often, however, patients complain of distress which is indefinite in character and situation. All they can tell us is that they have "rectal" pain. This may refer to the anus, or more often to symptoms originating in the sacrum or coccygeal region, or occasionally in the pelvis. It is, therefore, always necessary to make a thorough ano-procto-sigmoidoscopic examination. By excluding local lesions one can, then, look for causes elsewhere.

## METHODS OF EXAMINATION

For a proper diagnosis of terminal bowel lesions, at least three methods of examination are necessary: 1, Inspection; 2, palpation; 3, instrumentation of the anus, rectum and sigmoid.

The typical left Sym's position is most suitable for the purpose of routine proctological examinations. The patient should be covered with a sheet in such a manner that there is never any unnecessary exposure. Occasionally,

in obese patients, the knee chest position will better facilitate the examination.

## INSPECTION

Inspection of the anus and the perianal region should always precede any instrumentation. For this purpose, a direct good light will be found useful. After retraction of the buttocks, the physician, standing directly behind the exposed parts, will note:

1. Inspection may reveal a tender bluish mass that is an external thrombotic hemorrhoid, due to the rupture of a vein usually from straining at stool. It is evidence of a phlebitis of a branch of the inferior hemorrhoidal vein, and suggests deep-seated, low-grade infection.

2. Fissure in ano may be seen as a tear usually in the posterior commissure of the muco-cutaneous junction, when chronic, associated with an edematous tag of skin (sentinel pile). Chronic indurated fissure is characterized by marked fibrosis of the fissure bed and a loss of the elasticity of the anal tissues. The subcutaneous external sphincter muscle is sometimes exposed and severe anal spasm is associated.

3. The external opening of a pyogenic fistulous tract may be seen as a small cicatricial orifice near the anus; while a large irregular opening, surrounded by dusky violaceous tissue, suggests a tuberculous fistula.

4. By having the patient strain and retracting the buttocks, prolapsing hemorrhoids, as well as prolapse of the rectal mucosa can be identified.

5. Strangulated prolapsed internal *hemorrhoids* (usually ulcerated) may also be seen. The markedly edematous encircling skin, with black (gangrenous) hemorrhoids protruding from its center, is characteristic. They are often seen after childbirth, and efforts to reduce them are usually futile and dangerous.

6. Marginal or ischiorectal abscess may also be visualized. The former may be situated anywhere around the circumference of the anal canal. An anterior perianal abscess may be missed without careful inspection and palpation. An ischiorectal abscess usually occupies the lateral anal margin and swelling with fluctuation occurs fairly late.

## PALPATION

In examining for the cause of the para-rectal pain, palpation of the interior of the bowel with the right index finger must be done with gentleness. In the female, a vaginal examination is often of great assistance in differential diagnosis and in determining the extent of the lesion.

1. Digital palpation of the anal canal may reveal areas of tenderness, or induration (abscess). The tissues should always be palpated between the right index finger in the rectum and the thumb on the anal verge. The index finger, by gently stroking along the ano-rectal junction, may identify by touch many conditions—an enlarged papilla or crypt, internal hemorrhoids, a polyp, or an adenoma within the rectum,—all may be palpable.

A fibrous band, the so-called *pectin band*, may be palpable in the posterior muco-cutaneous junction. By interfering with the normal relaxation of the sphincter ani, it is a frequent cause of infection and of rectal constipation.

Under no circumstances should a digital examination be done on a patient with a painfully spastic sphincter, except after relaxation by a local anaesthetic. A pledget of cotton soaked in five per cent cocaine or metycaine, applied to the sphincter ani, will afford satisfactory anaesthesia.

2. Perianal (marginal) abscess is a crypt abscess which has burrowed between the fibers of the external sphincter muscle, and now involves a segment of the anal canal.

3. Submucous abscess, or intramural abscess, occurs beneath the mucous membrane covering the lower rectum, and may be found at any point in the circumference of the rectum. Those located in the anterior wall may be associated with *dysuria*. With gentle digital palpation, the outlines of a rounded tender mass may be made out. Occasionally it gravitates under the skin of the anal margin.

4. Superior pelvi-rectal abscess is stated to occur as a result of inflammation, or injury to the anterior rectal wall, or arise from infections of the bladder, urethra, seminal vesicle, prostate, uterus, or broad ligament. However, infection may be carried upward into these spaces by the lymphatics from infection at or

about the dentate line; and it occurs more often than is generally appreciated.<sup>1</sup> Symptoms are a sense of weight in the pelvis, and pain in the lumbar and sacral region and down the thigh. Digital examination will reveal a bulging mass laterally or posteriorly in the rectum. An almost pathognomonic sign is pain on pressure over the (perineum) annococcygeus portion of the external sphincter.<sup>1</sup>

5. Lymphogranuloma (lymphopathia) venereum is a systemic disease which appears in at least four different clinical entities,<sup>2</sup> but only the rectal form will be considered. The pathogenesis of the condition is a virus. Various theories maintain that inoculation of the rectal walls takes place either directly through the mucosa, or through the neighboring lymphatic supply. The late manifestation is that of an inflammatory indurated stricture beginning characteristically at the dentate line. A thickened indurated extensive lesion differentiates it from rectal strictures caused by gonorrhea and other diseases with which it was frequently confused in the past. There is usually a discharge of pus, blood, and mucus and often diarrhea. Palpation of the rectum is usually impossible because of the diminution in caliber of the lumen. In the female, vaginal palpation will reveal the extent of the rectal involvement. All cases of ulcerative procto-colitis, as well as atypical ano-rectal infections, should have a Frei test to rule out this condition. This, because lymphopathia venereum is protean in its manifestations.

6. Tonic spasm of the levator ani, coccygeus and pyriformis muscles: The result of this entity is often coccygodynia (low back-ache) or pain in the gluteal region and down the back of the thighs, neuritis, and many obscure pelvic symptoms. Frequently the cause of the spasm of these muscles may be found in disease of the anus and rectum. On high rectal palpation, there will be found a tonic spasm of the levator ani and coccygeus muscles on one or both sides, associated with tenderness. Frequently associated with these are found exquisitely tender sacral bursae.

1. Hibshman, Harry Z.: Supralelevator Abscess. Tr. Am. Proctol. Soc., 1937.

2. Frei, Wilhelm: Venereal Lymphopathia. Jr. A M., May 19, 1938.



7. One should never fail to palpate high up near the sacrum for a *malignant* lesion. By placing the patient in the dorsal knee chest position with the knees pressing down on the abdomen and the patient straining, one can often reach a height of six inches to the recto-sigmoid. About 64 per cent (Rankin) of intestinal cancers are in the rectum and sigmoid, and thus within the reach of the examining finger. Laxity in high digital examinations has been the cause of failure to recognize early malignancy in this area. Early subjective symptoms are often vague and indefinite, and referred to the lower abdomen. It is surprising how well nutrition is maintained even in advanced cases. The late symptom is the change in bowel habit (97.5 per cent), such as constipation in one previously with normal function or unexplained diarrhea. Rectal bleeding may be a warning sign. Pain is a late symptom of rectal cancer. Finally the symptoms of intestinal obstruction may supervene; but by this time the tumor has involved the circumference of the bowel and become fixed or metastasis has occurred. Diagnosis will most frequently be made if the mind is constantly alert to the problem and careful examination is made in all patients complaining of rectal symptoms.

#### INSTRUMENTAL EXAMINATION

Anoscopy will confirm and elaborate the conditions noted on inspection and palpation.

In the knee-chest position, the proctoscope will often reveal the interior of the rectum for a considerable distance. The rectal valves may be visualized, and occasionally adenomata which are situated on them. The instrument is then slowly withdrawn until the mucocutaneous junction appears in view. It is essential that it be inserted repeatedly, in order to definitely identify local lesions, as well as the junction of the modified anal skin with the rectal mucous membrane. This latter is particularly important in the injection treatment of internal hemorrhoids.

*Sphincter (crypt) abscess:* If, on anoscopic

examination, a drop of pus is present, it usually suggests a crypt abscess. The identification of the involved crypt is sometimes difficult, but its eradication is important because it is the origin of para and high rectal abscess.

The use of sigmoidoscope is of value in the diagnosis of all diseased conditions located in the rectum, and at the recto-sigmoidal juncture. The more important of these are ulcerated proctitis or colitis, malignancies and adenomata or polypi.

*Sigmoidoscopy should be performed prior to all ano-rectal operations especially hemorrhoidectomy, as only too frequently advanced rectal carcinoma is discovered in patients who have had a recent hemorrhoidectomy to cure rectal bleeding.*

*Ulcerative Procto-Colitis:* This lesion is confined exclusively to the rectum in approximately 20 per cent of patients.<sup>3</sup> Proctoscopy will reveal in the early stages miliary ulcers; while polypoid degeneration of the mucous membrane is characteristic of the chronic stage. More commonly, sigmoidoscopy will reveal extension as far up as the instrument can be passed. The mucous membrane is angry red, and friable, and bathed in pus and blood. Usually the extent of the lesion is determined by the x-ray barium enema. It is important to differentiate the early picture from gonorrheal proctitis (in women), and from infestations with *entameba histolytica*, ulcerated malignant lesions, and lymphogranuloma venerea.

*Malignancy of the Rectum and Sigmoid:* Sigmoidoscopic examinations in the case of malignancy of the bowel will determine five factors which are of importance from the standpoint of surgical curability:<sup>4</sup>

- a. Site of tumor.
- b. Type of growth.
- c. Size.
- d. The amount of fixation.
- e. Degree of obstruction.

Knowledge of these factors determines the operability of the growth.

Sigmoidoscopy is also important in the diagnosis of adenomata or polypi which, as single or multiple growths, are frequently found if carefully looked for. They are now considered pre-cancerous lesions. When found, removal

3. Rankin, Bargen, Buie: Chronic Ulcerative Colitis; the Colon, Rectum and Anus. W. B. Saunders Co., N. Y. C.

4. Yeomans, Frack C.: Carcinoma of Rectum and Recto-sigmoid. Medical Jr. and Record, May 21, 1924.



by the high-frequency electric snare through the sigmoidoscope is imperative. This method, rather than fulguration, is advised, because microscopic examination of the specimen is essential.

#### TREATMENT

The treatment of ano-rectal pain has been facilitated greatly since the introduction of the oil-soluble anaesthetics originally introduced by Dr. J. L. Mathesheimer, of Jersey City, and Dr. R. V. Gorsch, of New York. It has revolutionized the treatment of ano-rectal pain. It is used pre-operatively, as well as post-operatively, by injection around the rectum. Because of the prolonged anaesthesia, as well as marked relaxation of the sphincter ani, examination of painful lesions becomes comparatively painless; and likewise post-operative pain is reduced to a minimum. By the use of an oil-soluble anaesthetic, many minor ano-rectal lesions can be treated in the office, both medically and surgically, with very little discomfort.

It should be emphasized, however, that the method of injection is different from that of water soluble anaesthetics, and the technic must be learned.

Contraindications<sup>5</sup> to its use are suppurative processes around the ano-rectum and debilitated or metabolic conditions where tissue repair is likely to be poor.

1. The treatment of external thrombotic hemorrhoids, cryptitis, papillitis and fissure in ano has been considered in a previous paper.<sup>6</sup>

2. The treatment of *strangulated prolapsed internal hemorrhoids* is controversial, some authors recommending immediate surgery. The following procedure is recommended: An oil soluble anaesthetic is injected deeply into the tissues about the rectum. This will result in greater relaxation of the sphincter ani, with relief of pain and improvement in the circulation. With bed rest, mineral oil to insure soft bowel movement, hot sitz baths, and frequent applications of one-half strength aluminum acetate, the inflammatory reaction in and about the hemorrhoids will subside in a few days. Surgical intervention then may be safely performed.

3. *Para Rectal Abscess*: Early drainage of these abscesses limits their spread and minimizes their complications (fistulae). To perform this operation, a general or caudal anaesthetic is advised. The abscess should not merely be incised but should always be unroofed. Bleeding is checked, and the wound is lightly packed with vaseline or iodoform gauze. The pyogenic membrane with which nature has surrounded the abscess cavity is left intact. The packing is removed and lightly repacked daily until the abscess cavity has filled in. Since a majority of these abscesses originate in an anal crypt or infected fissure, these should be looked for. Excision of the primary focus with drainage of the abscess will cure the condition and avoid a secondary operation.

4. The treatment of *ulcerative proctocolitis*: There is apparently no specific treatment. The routine followed by the writer is as follows: A course of emetine hydrochloride followed by vioform or carbarson; high rectal instillations of five per cent argyrol; intravenous saline glucose for dehydration; and a high vitamin, low residue, high caloric diet, is given and brewer's yeast. Rest, both physical and mental, is stressed. For very toxic patients, small blood transfusions and oxygenation is indicated. Neoprontisil (oral) has been used in a few cases, also liver extract parenterally. Remission is all one may hope to attain, since a cure in the present state of our knowledge is doubtful. Colectomy is replacing ileostomy as a curative measure, and is of value in selected cases.

5. The treatment of *lymphopathis venerea*: Usually one sees this condition in its chronic stage, when rectal stricture has already occurred. This may be complicated by abscesses or fistulae. Diathermia and the use of Wales bougies will give much relief for the rectal stenosis. A preliminary caudal anaesthesia, or the injection of an oil soluble anaesthetic, will facilitate the above procedure by relaxing the stenosis. Mineral oil, nourishing food, and tonics are also indicated. Surgery is strictly limited to relief of local infections.

5. Gorsch, R. V.: Oil Soluble Anaesthetics in Proctology. Medical Records, Jan. 3, 1934.

6. Gerendasy, J.: The Office Treatment of the Common Rectal Disorders. Jr. Med. Soc. of N. J., Dec., 1938, p. 713.

6. *Spasm of levator ani muscles*: Before treatment is instituted, all the local ano-rectal lesions should be eradicated. The condition responds to massage of the affected muscles.<sup>7</sup> With full-length finger insertion of the finger in the rectum, the belly of the muscles lying in the pelvis is gently stroked. The massage is at first done very lightly, because of extreme tenderness; and at subsequent visits the pressure is increased. Treatment is given bi-weekly until the symptoms have disappeared. The injection of an oil-soluble anaesthetic into the affected muscles will occasionally result in prompt relief where the results of the massage are slow or unsuccessful.

7. *Submucosal abscess*: The condition at times has to be differentiated from a thrombotic internal hemorrhoid which gives much the same signs but usually there is no rise of temperature. Occasionally the submucous abscess ruptures spontaneously. To secure complete healing it is best to incise the abscess intrarectally. A caudal or low spinal anaesthesia will facilitate this procedure greatly. The wound is swabbed out with 95 per cent phenol, followed by alcohol. It is then packed tightly with dry gauze to control the bleeding, a piece of which extends out through the anus. A rubber drainage tube is also inserted to allow the escape of flatus. The packing is removed after two days and is not replaced. Besides irrigating the rectum with hot 1 to 10,000 potassium permanganate solution daily, the gloved finger is inserted to smooth out the tract.

8. *Superior rectal space abscess*: The treatment of superior rectal space abscess entails a thorough knowledge of the anatomy of the parts. The principles involved are that the drainage must be from a point outside of, but

close to the anal canal; that no incision should be made through the rectal musculature; and that the integrity of the levator ani and external sphincter muscle should be preserved. The object is thorough drainage; and often that is all one can hope to accomplish. It is better to have a chronic discharging sinus than fecal incontinence. Iodoform packing is lightly inserted into the cavity for 24 to 48 hours; and after its removal, irrigations are not advised.

9. *Carcinoma of the rectum and sigmoid*: Only generalities can be stated here. Coöperation between the family physician and the proctologist would lead to the identification and the eradication of malignant disease in its early stages when a prospect of cure is almost a certainty. It would also abolish the regrettable practice of labeling cases inoperable when in fact they are for the most part operable in the hand of experts.

Irradiation, and deep x-ray therapy, in the hands of experts may occasionally temporarily arrest, or even cure, malignancy in this area; but complete cure is possible only at the hands of a specialist in this type of surgery.

It seems needless to warn of the dangers of the many pseudo-scientific cures which are being popularized in the lay press. However, one occasionally encounters even intelligent members of the profession led astray by the false promises of these so-called "cures". Many of these "cures" not only fail to destroy the growth, but they complicate the work of the surgeon who finally has to cope with the condition. It is a deplorable fact that, in spite of the accessibility of the parts, most cases of carcinoma of the rectum and sigmoid are not diagnosed until nine to twelve months after the inception of the growth.<sup>8</sup> Too many are treated for bleeding piles or colitis. An obvious cure for this state of affairs is to have an expert routinely sigmoidoscope every patient complaining of ano-rectal symptoms not amenable to simple measures.

7. Thiele, George H.: Tonic Spasm of the Levator Ani, Coccygeus and Piriformis Muscles. Tr. Am. Proctol. Soc., 1936.

8. Lynch, J. M., and Hamilton, G. J.: Operative Mortality in Inoperable Cancer of the Recto-Sigmoid. Amer. Jour. Surg., 1935.

## DIFFERENTIAL DIAGNOSIS BETWEEN ACUTE DISEASES OF THE CHEST AND OF THE ABDOMEN\*

By GEORGE P. MULLER, M.D., Philadelphia

In any discussion of the differential diagnosis between acute disease in the chest and in the abdomen, we must first appreciate that (except for the extension of an infective process from one cavity to the other) the matter of sensory nerve supply assumes prime importance.

The diaphragm is a complicated structure built up by tissue coming from different sources. Part is derived from cervical myotomes displaced backwards as the diaphragm descends to its permanent level. In this descent, portions of the third, fourth and fifth cervical nerves fuse into the phrenic nerve. While this is a motor nerve, yet under strong stimulation the afferent sensory fibers retain their ability to carry impulses to the cervical cord and thereby give rise to referred pain in the neck. The phrenic nerve fibers penetrate into the peritoneal and pleural coverings of the diaphragm.

The outermost portion of the diaphragm is supplied by the lower six intercostal nerves. This area is much more sensitive to sensory stimuli than is the central area. Finally, the diaphragm is innervated by the diaphragmatic sympathetic plexus. Thus certain conditions in the thoracic cavity may cause pain referred variously by the phrenic, the lower intercostals, or the sympathetic plexus, and projected to the abdominal wall.

### SHOULDER PAIN

Conditions in the abdomen rarely are referred as pain to the thorax. The well-known shoulder-tip pain, supposed to be constant in gall-stone disease, actually occurs in less than 10 per cent of all cases of gall stones. It certainly is not diagnostic of cholelithiasis. This pain must be referred by the phrenic nerve by way of the supra-acromial nerve which might

be considered as a sort of superior branch from the phrenic as both arise from the middle cervical branches. Gall-stone colic *per se* cannot give rise to shoulder-tip pain for there must be associated adhesion formation involving the peritoneum high up where it reflects on to the diaphragm. And perforated ulcer into the lesser cavity may cause irritation of the left half of the peritoneal surface of the diaphragm, thus provoking referred pain to the left shoulder. After splenic rupture, the blood under the diaphragm may have the same effect.

Diaphragmatic abscesses caused by the "tracking up" of infection from an appendiceal abscess, or from leakage from a liver abscess, may cause diaphragmatic irritation and shoulder pain. Subphrenic abscess also may cause an inflammatory reaction on the pleural side of the diaphragm, giving rise to fluid in the costophrenic sinus and lower part of the cavity, with resultant pain in the side of the chest from irritation of the intercostals.

After operation upon the abdomen, pleurisy or an infarct causing pneumonitis may produce pain in the lower chest.

### INTRATHORACIC INFLAMMATION

Among diseases in the thoracic cavity which may cause abdominal phenomena, we must consider pneumonia, coronary thrombosis and pneumothorax. Lobar pneumonia is the most frequent intrathoracic cause of abdominal pain, and if ushered in with nausea, vomiting and abdominal tenderness, may focus the entire attention to the abdomen.

Sometimes patients, especially children, develop an acute upper respiratory infection which rapidly spreads into the chest, and which a few days later produces acute abdominal pain. I am inclined to believe that in these cases the streptococcus produces an acute adenitis in the abdomen as well as in the neck. As clumps of lymph nodes are situated about the

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ileocecal junction, the patient complains of right iliac fossa pain and tenderness.

If the onset is typical and unilateral rigidity absent, we are inclined to wait, but if the tenderness is distinct and causes "wincing" it is usually safer to operate. Perhaps I can put the position best by stating that one must balance the symptoms and signs in the chest and abdomen along the line of onset and preponderance. An essentially "abdominal" onset in the presence of a mere cold suggests appendicitis; a bronchopneumonia with developing abdominal symptoms suggests the other. Too much stress should not be laid upon vomiting because if the initial chill of pneumonia closely follows a heavy meal, whether the patient is an adult or a child, vomiting is likely to occur.

#### PHYSICAL FINDINGS

Usually we can make the diagnosis by meticulous physical examination but if doubt exists and a portable x-ray examination can be made, this should be done. Certainly the greatest spasm, pain and tenderness will be in the upper right abdomen as the cause of this referred pain is the irritation of the peripheral portions of the abdomen supplied by afferent fibers from the lower six intercostal nerves. Nor is there any necessity that the pneumonia be in the lower lobe because there is a contact from the middle lobe even with local pleurisy at this point. Of course in a real diaphragmatic pleurisy the tenderness and rigidity will be greatest.

#### HEART DISEASE

Acute coronary occlusion is the most severe if not the most frequent manifestation of coronary disease and typically is ushered in by persistent severe pain beneath the sternum. The pain may radiate downward into the epigastrium or over to the liver and gall-bladder area; or it may be localized beneath the tip of ensiform cartilage, accompanied by epigastric fullness with nausea and vomiting. The symptoms of coronary occlusion are well known and the physician should not be deceived by the epigastric reference of the pain. The patient is apprehensive and restless, whereas in perforated ulcer he is likely to be "frozen to the bed".

Dyspnea and cyanosis are suggestive. During the attack the blood pressure may fall to below the patient's average. The rigidity of the upper abdominal muscles is never so great as in acute perforation, nor is there the same degree of tenderness as in acute cholecystitis. Since in coronary thrombosis fever and leucocytosis are frequent, these signs are not important in diagnosis. Pericardial friction rub is almost diagnostic. The heart sounds seem distant. The electrocardiogram is not always to be depended on until after the fifth or sixth day of the attack.

Early coronary sclerosis may cause discomfort after eating and such patients are often treated for "indigestion". They may, however, die from an acute occlusion or sudden myocardial failure. Close questioning will show that some symptoms appear when an extra load is thrown on the circulatory apparatus—typically when moderate exertion is attempted soon after a meal.

We should also remember angina pectoris, the first cousin to coronary thrombosis, abdominal angina appearing particularly in arteriosclerotics and heart failure from whatever cause, all of which may produce severe abdominal pain with nausea and vomiting. Spontaneous pneumothorax may simulate acute abdominal affections, and I have seen two such cases, in one of which the abdominal symptoms were sufficiently mild to justify delay. The true condition was soon diagnosed. In the other case, the symptoms were absolutely typical of an acute perforated ulcer with most intense board-like rigidity. I operated upon this man and found nothing. Twelve hours later he developed the signs of a pneumothorax. Presumably the first escape of air occurred in the mediastinum and involved the phrenic nerve or sympathetic; or it may be that the early air in the chest caused intercostal nerve refraction which was projected to the epigastrium. In this case, we knew of no reason for the pneumothorax; hence it was considered spontaneous. This man recovered. Three months later he had another attack which was treated simply by aspiration of the chest. Two years later he was entirely well.



### OTHER THORACIC LESIONS

I have seen two patients with intrathoracic hemorrhage both of whom were suspected of having upper abdominal disease. In one case, the medical attendant wanted me to open the abdomen for possible acute pancreatitis (at that time we were operating early for acute pancreatitis). I could not accept this diagnosis because there were marked chest phenomena. An emergency x-ray examination showed a large mass in the thorax. He died shortly and at autopsy a ruptured hematoma was found, arising from a thymic tumor.

The other case occurred in a man of fifty who jumped into a swimming pool and immediately experienced severe epigastric pain and prostration. In the hospital, the provisional diagnosis was acute gall-stone attack because he had a history of gall-bladder symptoms for some years. We also thought of an acute pancreatitis. He improved but I called Dr. Deaver in consultation and he agreed that it probably was acute pancreatitis. We both advised delay. On the following morning he developed another violent attack of epigastric pain and died. At autopsy, rupture of the thoracic aorta was found. A slit had occurred along the line of an arteriosclerotic patch. As the mediastinum and chest were full of blood, presumably the first attack was a mild bleeding which produced his referred pain.

Diaphragmatic hernia is another cause of pain in the epigastrium and lower chest. This gives rise to symptoms of mild dysphagia, low chest discomfort and epigastric burning following a meal. Mild cases are rarely recognized except by x-ray examination, but when a large part of the stomach has herniated, the symptoms will resemble those of ulcer. Indeed, ulcer does occur in cases of long-enduring hernia.

Herpes zoster, whether involving thoracic or abdominal segments may cause severe abdominal pain with marked tenderness and hyperes-

thesia. Diagnosis is difficult in the prevesical stage but the distribution of the hyperesthesia along the course of nerve trunk is the best clue.

Our attention has been called to diabetes as a cause of marked abdominal tenderness in the pre-coma phase. If this is associated with nausea, vomiting and gastric distention, the question of an acute abdomen often arises.

### PROCEDURE

The importance of the differential diagnosis between thoracic and abdominal conditions causing pain is that the chest condition rarely requires operation and frequently would be aggravated by it. If the incidence is not very acute, a short delay usually brings out the correct diagnosis, particularly when proper laboratory assistance is available. On the other hand, when the abdominal pain is hyperacute one is confronted with the need of operating promptly if there is any suspicion of penetrating ulcer or of acute appendicitis.

As we rarely operate immediately on acute disease of the biliary tract, this condition can be put out of the picture. Fever and increased leucocyte count are not of such great importance because we have these in both pulmonary infection and coronary occlusion. Unless I suspect acute perforation of ulcer I am inclined, in all doubtful cases, to wait for a number of hours because the salt solution, morphine and rest do no harm to the patient with the acute abdomen and enable one to evaluate the symptoms more carefully.

The range of diaphragmatic motion as noted by watching the lift of the ribs should be important. Unfortunately, the rigidity of the abdomen from intraabdominal disease will cause the same symptoms as would occur in some of the chest conditions. Accurate differentiation must be based then not so much on the pain itself as upon careful consideration of the history, symptoms and physical signs.

## DIFFERENTIAL DIAGNOSIS IN PERIPHERAL VASCULAR DISEASE\*

By FERDINAND C. DINGE, M.D., East Orange, N. J.

Organic vascular cases have associated with them a vasospastic element and vasospastic diseases, as such, may in their late state develop organic changes. These vasospastic changes depend upon factors at times beyond the control of the physician and must be reckoned with when making a prognosis of the affection being dealt with.

### CLASSIFICATION

At this point a simplified classification of these conditions will be made. These disorders are usually placed in two main divisions, (A) the organic, by far the most common, and (B) the vasospastic.

#### A. The organic types are:

1. Arteriosclerosis obliterans with or without associated diabetes.
2. Thrombo-angiitis obliterans (Buerger's disease).
3. Simple thrombosis or embolism.
4. Arteritis, infectious or chemical.
5. Aneurysms with or without thrombosis.
6. Varicose veins and ulcers.
7. Thrombo phlebitis and venous embolism.

#### B. The vasospastic types, in order of importance, are:

1. Raynaud's disease.
2. Acrocyanosis.
3. Erythromelalgia.
4. Vasospastic conditions associated with infections or traumatism.

### HISTORY

In any differential diagnostic procedure of peripheral vascular diseases a detailed history is of prime importance. See chart I on opposite page for tabular summary.

Sex plays an important part in differential diagnosis. Thrombo-angiitis obliterans is rare in women, and while arteriosclerosis obliterans occurs in both, the male again has the edge as to frequency. Raynaud's disease and other vasospastic conditions occur chiefly in females.

These disorders occur in all races, Buerger's disease up to 40 per cent or more in the Hebrew

race. This figure varies with the place at which the statistics are gathered. Buerger's disease has not been found in the full-blooded Negro.

Vaso spastic diseases occur in the early age groups from adolescence to the climacteric while arteriosclerosis occurs later. Thrombo-angiitis occurs early in life and chiefly in males, so it can be easily differentiated.

Tobacco, although not an etiologic factor in peripheral vascular diseases, plays an important part in treatment. One must investigate to what extent an individual uses it, for it has a definite vaso-constricting effect.

Pain in vascular disease manifests itself in numerous ways, depending on the rapidity of onset. In arteriosclerosis this may first present itself in the form of intermittent limp or fatigue which may go on for some time before intermittent claudication sets in. Then intermittent claudication may follow. These symptoms are often followed by localized pain, principally in the foot, which comes and goes at first and tends to become constant. Such pain often prevents sleep at night. This may manifest itself as a cramp, and may be so severe that dorsi-flexion of the toes results. Pain in well-developed Buerger's disease is agonizing and the patient usually complains of a sensation like a knife-thrust into the calf. Later in both Buerger's and arteriosclerosis, rest pain is a constant complaint. Pain accompanying ulcers or gangrene frequently is out of proportion to the presenting lesion. One must differentiate this type of occlusion pain from that of sudden arterial closure by an embolus. The antecedent history usually gives a clue. Venous thrombosis of the iliacs and femorals may begin with severe pain. The pain is often aggravated by elevation of the extremity and diminished on dependency. At times pain is slight or absent in diabetic arteriosclerosis. Raynaud's disease rarely produces pain unless accompanied by organic changes. Then it is usually late. In erythromelalgia, pain is generalized over the body, in the form of a burning sensation rather than an ache.

\* Read at the Annual Meeting of The Medical Society of New Jersey, May 20, 1941.

CHART I.  
HISTORY IN DIFFERENTIAL DIAGNOSIS OF PERIPHERAL VASCULAR DISEASE

	THROMBO-ANGIITIS OBLITERANS	ARTERIOSCLEROSIS	RAYNAUD'S DISEASE	ACROCYANOSIS	PRIMARY ERYTHRO- MELALGIA
Sex	Males, 99%	Males, 90%	Females, 95%	Usually females	Females, 70%
Race	Any. Hebrews predominating	Any	Any	Any	Any
Age	25-45	55-85	17-35	Young adult life	30-50
Constitution	All types	All types	Asthenic emo- tional instability	Asthenic emo- tional instability	Sthenic
Previous infec- tions	Frequent	Frequent	No known rela- tion	Possible local relationship	No known relation
Tobacco	In large amounts	Moderate	Not frequent	Not frequent	Not frequent
Rye bread	Frequent	Occasional	Occasional		
Claudication	Usually present	Usually present	Absent	Absent	Absent
Pain	Present	Usually present	Rare	Occasional	Present
Rest pain	Usually severe	Occasionally mild	Absent	Absent	Mild to severe
Type of pain	Sharp and knife- like	Aching	Absent	Absent	Burning
Site of lesion	Any extremity, usually unilateral at one time	Lower extremity often bilateral	Bilateral, fre- quently upper extremity	Usually unilateral only one digit	Usually bilateral, frequently entire body

CHART II.  
FINDINGS IN DIFFERENTIAL DIAGNOSIS OF PERIPHERAL VASCULAR DISEASE

	THROMBO-ANGIITIS OBLITERANS	ARTERIOSCLEROSIS	RAYNAUD'S DISEASE	ACROCYANOSIS	ERYTHROMELALGIA
Postural color					
Changes	Excessive rubor on dependency. Excessive pallor on elevation	Same	None	None	None
Effect of cold	Mild cyanosis pallor in 30%	Slight cyanosis in 15-20%	Pallor and cya- nosis in all cases	Cyanosis	Never
Gangrene	Common	Common	Rare	Rare	Never
Types of ulcers	Moist, inflamed, discharging	Usually dry	Small punched- out superficial	Same	None
Arterial pulsation	Diminished to absent	Diminished to absent	Normal	Normal	Excessive
Edema	Frequent	Occasional	Possible sclero- derma	Absent	Absent
Superficial phlebitis	30% of cases	None	None	None	None
Temperature of extremity	Low	Low	Low	Low with spasm, high with relaxa- tion	High
Visualization of capillaries	Hazy, dilated stasis	Moth eaten small stasis	Greatly dilated. Full in rubor stage. Stasis	Large, dilated, usually stasis	Huge, grotesque sluggish flow
Visualization of arteries	With contrast dye x-ray shows blockage	Same plus arteriosclerotic plaques	Negative	Negative	Negative



The lesion is in the lower extremities in both arteriosclerosis obliterans and thrombo-angiitis obliterans (T. A. O.). In T. A. O. the lesion is unilateral, while in arteriosclerosis it is bilateral. On rare occasions T. A. O. may involve all four extremities. Raynaud's has a predilection for the upper extremities and is bilateral, at times quadrilateral. Acrocyanosis is unilateral and limited to one or two digits. Erythromelalgia occurs bilaterally and affects the entire body.

#### FINDINGS

Observations on patients with peripheral vascular conditions should be made in a warm room after exposure of the extremities for 10 to 15 minutes to obviate accidental vasomotor constriction. See chart II on previous page.

The color of the extremity on elevation and dependency is significant. Excessive rubor, deeper than normal pink color coming on slowly and having a deep hue, is characteristic of obstructive or occlusive vascular disease. On elevation to an angle of 30 or 45 degrees the color rapidly fades out and the skin takes on a cadaveric appearance. A cramp is sometimes brought out on elevation. In Raynaud's disease, color changes are provoked only after exposure to cold or during an emotional reaction. Color changes may be brought about by placing the hands in cold water. Position plays no part in acrocyanosis or erythromelalgia.

Cold produces cyanosis and pallor in a third of the cases of T. A. O. and slight cyanosis in arteriosclerosis, while in Raynaud's pallor, cyanosis, rubor, are always present during an attack. In acrocyanosis unilateral spasm limited to one or two digits is the rule.

Gangrene is common to all obstructive lesions sooner or later. Onset is determined by how rapidly an adequate collateral circulation can develop and upon the severity of the condition. T. A. O. at times is a slowly progressing lesion, and at other times fulminating. Infection also plays a part in hastening gangrene by the thrombosis of arterial and venous channels about the infected area. Ulcers are usually

the result of undue pressure at a point where the blood supply is poor. These are inflamed, moist and discharging in T. A. O., while in arteriosclerosis they are dry, unless osteomyelitis sets in. Ulcers in Raynaud's are small and punched out in the early stages. Gangrene in Raynaud's is rare and it never occurs in erythromelalgia.

Arterial pulsation in obstructive lesions is usually diminished or absent. This is determined by palpating the peripheral vessels, such as the dorsalis pedis, posterior tibial, popliteal and femoral arteries. More accurate determinations of the pulsation in these vessels is accomplished by means of an oscillometer, which is also of value in localizing an occlusion resulting from embolus or in determining the level at which a safe amputation can be accomplished. This instrument can now be obtained for the price of a standard sphygmomanometer. The vasospastic diseases show no changes in pulsation of the peripheral vessels except when vasospasm is extreme.

In occlusion, the temperature is usually low and permanently so, while in vasospastic types the temperature is low only during the spastic stages. In most cases differences in temperature of the extremities can be determined by manual examination. For finer observations and for determining progress, the thermocouple is of value. Temperature recordings before and after, nerve block, paravertebral block or spinal anaesthesia determine the degree of vasospasm present. These fluctuations aid in evaluating prognosis. The greater the degree of difference between readings the better the prognosis.

In borderline cases, the x-ray is of value for visualizing the vessels. Arteriography may locate the point of obstruction, suggest the caliber of vessels and, above all, determine the nature of the collateral circulation in severe arterial disease. It is not of vital diagnostic aid, but is one step in the further confirmation of a specific condition.

Other procedures such as capillary study can be used but are not essential for positive diagnosis.

# STATISTICS ON OTHER ACCIDENTS OF CHILDBIRTH AS A CAUSE OF MATERNAL MORTALITY IN NEW JERSEY

MATERNAL WELFARE ARTICLE NUMBER SIXTY-SIX

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

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Chief Advisory Obstetrician, Bureau of Maternal and Child Health,  
State Department of Health

This is the sixth article on New Jersey Maternal Mortality Statistics for 1940.

The map (Fig. 9) shows the relative maternal mortality rates of the counties due to "Other Accidents of Childbirth" for the three-year period ending in 1940. While the rate is a little higher than in the period 1937 to 1939, there are six counties which had no death due to this group of causes, against five in the preceding period. These were all rural counties in both series.

The graph (Fig. 19) shows the rate for this classification for ten years. The solid line is the State rate; the dotted line, the rural rate; and, the broken line, the urban rate. The mortality rate for Other Accidents of Childbirth was 4.8 per 10,000 live births in 1937. Since then the rate has steadily increased to 5.9 in 1940.

The urban mortality rate with the larger number of births follows the State rate closely while the rural rate varies considerably and has been below the urban and State rates for the last three years.

It may be thought that the higher mortality rate in urban counties is due to the transfer to hospitals of emergency cases originating in rural counties; but this is not true. Of 34 cases in this classification only one patient living in a rural area died in an urban county, and as she was a private patient of an urban physician, this case was properly charged to

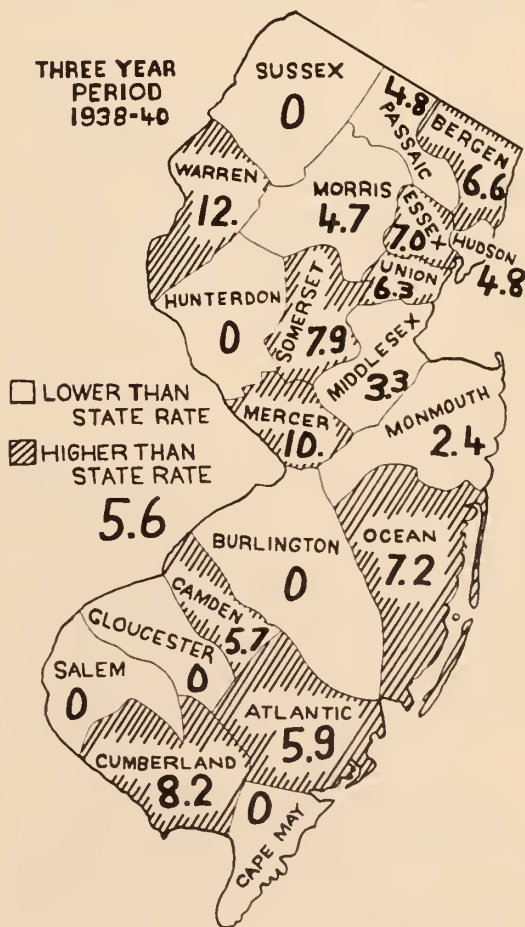
the urban county. This is case No. 56 briefly described under "cesareans".

Brief histories of the cases follow:

## UNDELIVERED (1)

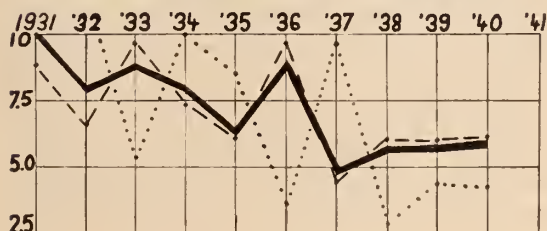
Case 170.—Grav i, para 0. Labor 24 hours. Prepared for cesarean. Spinal anesthesia. Patient died before operation started. Post mortem cesarean. Live baby. See comment at end of article.

## OTHER ACCIDENTS OF CHILDBIRTH



RATES ARE PER 10,000 LIVE BIRTHS

## OTHER ACCIDENTS OF CHILDBIRTH



**DIED DURING DELIVERY (4)**

Case 82.—Grav xiii, para ii. Labor at home 48 hours followed by rupture of uterus. Sent to hospital. Stillbirth. Large baby.

Case 52.—Reported under versions.

Case 101.—Reported under forceps.

Case 74.—Grav v, para iv. Age 40. Pendulous abdomen. Labor 14 hours. Pulse became imperceptible and patient died. Stillbirth extracted. Uterus found ruptured.

**NORMAL DELIVERIES (5)**

Case 11.—Grav i, para 0. Delivered at home, sent to hospital with retained placenta and pneumonia. Died 10 days later. Live baby.

Case 20.—Grav iii, para ii. Delivered at home. Sudden death 2 hours later. Live baby.

Case 91.—Grav v, para iii. Hospital delivery. Adherent placenta. Heart disease. Shock. Lived 4 days. Live baby.

Case 123.—Grav xii, para ii. Spontaneous delivery. Shock. Rupture of uterus. Died immediately. Live baby.

Case 107.—Grav v, para iv. Midwife delivery at home. Shock. Sent to hospital and transfused. One week later had another transfusion and became suddenly worse and died. Apparently transfusion death. Stillbirth.

**VERSIONS (10)**

There were six stillbirths and four live births, one of which died soon after delivery.

Case 24.—Grav x, para iii. Ruptured uterus, possibly before version. Stillbirth.

Case 39.—Grav vii, para v. Labor 3 days. Forceps delivery attempted. Ruptured uterus. Stillbirth.

Case 51.—Grav i, para 0. Labor 40 hours. Forceps delivery attempted. Ruptured uterus. Stillbirth.

Case 86.—Grav ix, para vii. Prolapsed arm. Ruptured uterus. Live baby.

Case 98.—Grav ii, para 0. Version at home. Baby died. Ruptured uterus.

Case 7.—Grav i, para 0. Version after long labor. Live baby.

Case 33.—Grav v, para iv. Version after attempted forceps delivery. Stillbirth.

Case 52.—Grav x, para v. Labor 33 hours. Attempted forceps delivery. Patient died during delivery. Live baby.

Case 95.—Grav i, para 0. Prolonged labor. Stillbirth.

Case 140.—Grav viii, para vii. Prolapsed cord and arm. Stillbirth.

**BREECH DELIVERIES (NO VERSIONS) (2)**

Case 106.—Grav i, para 0. Heart disease, spontaneous delivery, manual extraction of placenta. Died of heart condition and shock. Baby born alive but died.

Case 166.—Grav iii, para ii. Retained placenta. Shock. Possibly embolism. Stillbirth.

**FORCEPS DELIVERIES (7)**

Cases 33, 39, 51 and 52 reported under versions.

Case 90.—Grav i, para 0. Quinine grs. x, q 2 hours for 3 doses on second day of labor. High forceps delivery. Patient died half hour post partum. Live baby.

Case 94.—Grav i, para 0. Low forceps extraction. Adherent placenta. Manual extraction. Patient died 6 hours p.p. Stillbirth—13 lbs.

Case 101.—Grav i, para 0. Low forceps delivery. Ether anesthesia  $3\frac{1}{2}$  hours after breakfast. Patient aspirated vomitus into trachea and died. Live baby.

**CESAREANS (11)**

Case 2.—Grav i, para 0. Placenta previa. Patient died of pneumonia 2 weeks post partum. Live baby.

Case 26.—Grav v, para iv. Age 44 years. Long labor. Fetus died during labor. Patient died 9th day post partum.

Case 56.—Grav ii, para i. Large cyst in vagina not discovered until 15 hours in labor. Heart failure. Live baby. Patient died  $2\frac{1}{2}$  days post partum.

Case 65.—Grav iii, para ii. Labor pains stopped. Operation followed by shock. Anuria followed 1st transfusion. Jaundice followed 2nd transfusion. Baby died during labor—10 pounds 7 ounces—erythroblastosis. Patient died 9 days post partum.

Case 114.—Grav iv, para iii. Placenta previa and large fibroids. Died 2 hours p.p. Stillbirth.

Case 115.—Grav ii, para i. Hernia of bladder. Lived 1 hour after operation. Live baby.

Case 134.—Grav ii, para i. Previous section. Small pelvis. Shock. Died 4 hours p.p. Live baby.

Case 135.—Grav i, para 0. Age 37 years. Toxic. Labor 36 hours. Operation followed by shock. Lived 2 hours. Live baby.

Case 138.—Grav ii, para i. Private patient. Age 27 years. Small pelvis. Elective cesarean. Shock. Died 1 hour later. Live baby.

Case 154.—Grav ii, para i. Previous section. Shock. Died 2 hours p.p. Live baby.

Case 183.—Grav iii, para ii. Small pelvis. Previous cesarean. Heart disease. Died 1 week post partum. Baby not mentioned in history.

**COMMENT**

In studying the statistics and histories of these cases several points require special mention.

Heart disease was a contributing cause of death in a number of cases, and pneumonia occurring after delivery was mentioned a few times.

Ruptured uterus was a frequent cause of death. Sometimes it followed a long labor and one-half the deaths following version were due to this cause.

Spinal anesthesia was the cause of one death and under the classification of toxemia there was another. Both patients died immediately after the spinal injection had been given, be-



fore the cesarean operation had started. It is recommended by some anesthetists that in giving a spinal anesthetic a smaller dose of the sedative than usual should be given to pregnant women. It should certainly be used with caution.

Suffocation due to inhalation of vomitus while taking an anesthesia is a cause of death every year, though fewer cases occurred in 1940 than in 1939. The closed mask used so generally today is partly responsible for this cause of death, since while it is in use it is not easy to tell whether the patient is vomiting or gagging. The mask should be removed at once and patient's head turned to one side. It should never be fastened on the face of an obstetric patient. With care this complication should never occur. The open mask with chloroform or ether is safer.

#### TRANSFUSION DEATHS

Every year some transfusion deaths occur and it is only recently that a cause has been suggested. Dr. Philip Levine of the Beth Israel Hospital in Newark has found that in patients who have had repeated abortions or stillbirths previously or in cases of erythroblastosis, the Rh factor in the blood of the mother is negative. If a donor with a positive Rh is used (such as the husband) a reaction of serious

consequences may follow. This means that we should test for the Rh reaction before transfusing our obstetric cases. The usual typing is not sufficient.

#### PROLONGED LABOR

Prolonged labor is frequently a contributing cause of death and should be avoided. Walking during the prenatal period is an important factor in settling the head into the pelvis. If there is no progress after a brief trial labor, a prompt decision should be made as to the procedure to follow.

#### HOSPITALIZATION

The proportion of patients delivered in hospitals in New Jersey has gradually increased, reaching 85 per cent in 1940. We must make more of an effort to improve the rate for "Other Accidents of Childbirth". It can be done by better prenatal care, more closely watched labors, earlier decision to do a cesarean, fewer versions, and better technique at delivery.

The hospital has an important responsibility in these cases. Routine procedures should be checked and rules for consultation enforced. It is not enough to have a well-equipped hospital. There must be supervision by physicians with sound clinical judgment.

144 Harrison Street

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## A LESSON FROM A DEATH CERTIFICATE

### NUMBER THIRTY-SEVEN

Primigravida. Gestation eight months. Gradually becoming toxic. Blood pressure rose to 180/100. Urine showed four-plus albumin. Much edema.

Active treatment given. All symptoms improved. Patient refused to have labor induced at eight and one-half months because she was improving.

Suddenly she became worse and had convulsions and died.

This shows how important it is to interfere when a marked toxic case shows improvement and not to attempt to carry the case to term and take the risk of a fatal result.

A. W. BINGHAM, M.D.

## STATE ACTIVITIES

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### PROPOSED CONSTITUTIONAL AMENDMENT

At the Annual Meeting of the House of Delegates held in Atlantic City May 20, 21 and 22, 1941, the following Amendment to the Constitution was presented in writing, considered by the Committee on Constitution and By-Laws and recommended for adoption by a vote of the House of Delegates.

*Proposal to make the President of The Medical Society of New Jersey an ex-officio member of the Judicial Council.*

"In the Constitution, change Article 7 by inserting in the sixth line after the word 'collectively', the following words: 'together with the President who shall be a member ex-officio'.

"In the By-Laws, Chapter 7, Section 1, add at the end of the section, after the word 'year', the following words: 'The President shall be a member of the 'Council ex-officio'."

This communication is published in compliance with article 12 of the Constitution of The Medical Society of New Jersey.

ALFRED STAHL, M.D., Secretary.

This proposed amendment comes before the House of Delegates for final action at the Annual Meeting in April, 1942.

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### OCEAN COUNTY TRANSFUSION FUND

The Ocean County Transfusion Fund was first suggested by Dr. Raymond A. Taylor of Lakewood in March, 1938. At his invitation the Woman's Auxiliary to the Ocean County Medical Society sponsored the organization and approached all local groups in the community for coöperation. The organization which now operates the Fund is composed of members of the Ocean County Medical Society, their Auxiliary, and a few laymen.

Everyone who receives a transfusion is asked to pay \$35.00 into the Fund. Of course indigents receive the blood gratis. Each donor receives \$5.00 for any amount of blood less than 400 cubic centimeters, and \$10.00 for donations of larger amounts.

Their experience is that for every ten paid transfusions, there are 25 free ones, and for that reason the Fund often runs a little low

and is itself in need of a transfusion. At this point the Woman's Auxiliary and other donating groups usually contribute money. In general, however, the system is almost self-supporting and has had no need to call for any major financial assistance. The Fund is incorporated, its purpose being, according to its charter: "To promote and protect the welfare of those requiring blood transfusions, which are not to be denied to any person or persons regardless of race, color or creed, or ability to pay."

All donors are Wassermann-tested twice a year. Most hospitals perform a Kline or Kahn test immediately before transfusion as an additional check.

Because the blood is typed and listed in advance, it is possible to secure a transfusion of any type at short notice.

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### MOVING PICTURE FILMS FOR OUR ANNUAL MEETING

The Committee plans for a moving picture theatre during the Annual Meeting of The Medical Society in April. New Jersey physicians who have original scientific films of interest to the general practitioner are urged to coöperate by offering presentation of their pictures. While sound films in color are preferred,

silent pictures in black and white will be acceptable if of sufficient interest to the doctor.

Members having suitable pictures are requested to write to Dr. LeRoy A. Wilkes at the Executive Offices for an application form and further information.

## PASSAIC COUNTY RADIO PROJECT

"Your Health", the program of the Passaic County Medical Society, made its debut on September 8, 1941, and has continued every Monday at 11:45 a. m., from the WPAT Studios, 115 Ellison Street, Paterson. The material for the program is prepared by the Public Relations Committee and is executed by the members of the Society. Dr. Joseph E. Mott, who is Chairman of the Public Relations Committee, acts as announcer and members are invited to present the subjects.

Station WPAT, owned and operated by the North Jersey Broadcasting Company, went on the air for the first time on May 10, 1941, and has made rapid strides in public appeal and popularity. Station WPAT operates on 1,000 watts and can be tuned in on the dial at 930 from 6:30 a. m. to 7:00 p. m.

The Passaic County Medical Society is grateful to the North Jersey Broadcasting Company for this opportunity for service (at no cost to the Society). The Public Relations Committee feels that this program will go far in fostering and maintaining good relations between the physician and the general public, while at the same time being an organized health service to the community.

Subjects presented to date and planned for this month are:

September 8, 1941—"Your Health", Sigurd W. Johnsen, M.D., President, Passaic County Medical Society.

September 15, 1941—"The Relation of the County Medical Society to the Community", Joseph E. Mott, M.D., Chairman, Public Relations Committee.

September 22, 1941—"Infantile Paralysis", Sandor A. Levinsohn, M.D.

September 29, 1941—"Fall Health Hazards", James E. Phelps, M.D.

October 6, 1941—"Cancer Is Curable", Jacob Roemer, M.D.

October 13, 1941—"Gallstones", A. P. Randazzo, M.D.

October 20, 1941—"High Blood Pressure", Julian Cohen, M.D.

October 27, 1941—"Diseases Children Should Be Protected Against", Irving Okin, M.D.

November 3, 1941—"The Common Cold", Frank B. Vanderbeek, M.D.

November 10, 1941—"Diabetes Mellitus", Albert G. Markel, M.D.

November 17, 1941—"Physical Therapy", Robert F. Dow, M.D.

November 24, 1941—"Tuberculosis", William L. Weintraub, M.D.

December 1, 1941—"The Common Cold", Frank B. Vanderbeek, M.D.

December 8, 1941—"Evils of Self-Medication", J. R. Budd, M.D.

December 15, 1941—"Common Eye Troubles", Jon Van Winkle, M.D.

December 22, 1941—"Heart Disease in Children", I. J. Wolf, M.D.

December 29, 1941—"New Year's Resolutions—Head Injuries", R. N. MacGuffie, M.D.

January 1, 1942—"Sickness Insurance or Your Own Private Physician", Edward C. Edlkraut, M.D.

January 12, 1942—"Some Common Skin Troubles", George K. Tweddel, M.D.

January 19, 1942—"Vitamins and Your Health", Paul B. Ferrary, M.D.

January 26, 1942—"The Crooked Spine", Roy R. Schubert, M.D.

## PORTRAIT OF DR. HAUSSLING

A portrait of Dr. Francis Reynolds Haussling, Past-President of The Medical Society of New Jersey, was presented to the Newark Memorial Hospital last month by Mr. and Mrs. Jacob L. Newman. The portrait was unveiled December 18 in the Trustees Room of the Hospital. In presenting the portrait, Mr. Newman said: "Dr. Haussling was a physician of the old school. He had no desire to accumulate wealth; his main purpose in life was to be serviceable to humankind, to alleviate suffering and to heal the sick and disordered. He ministered to mind and body selflessly. He was an example of the highest ideal of the noble profession of which he was so worthy

a member. His skill in operating and his standing among his colleagues was earned by his constant study and intense application to his professional work. He was connected with the Newark Memorial Hospital for a period of 35 years, and for the last 10 years was Chief Surgeon. His services have left an indelible impress upon an institution which is regarded as one of the outstanding hospitals of the state of New Jersey. Without deprecating the value or the efforts of others, this fine reputation which the hospital enjoys was due in a large measure to his rare skill, his undeviating attention and his intense loyalty to the institution."



## NEW JERSEY PHYSICIANS' COMMITTEE FORMED

A New Jersey affiliate of the National Physicians' Committee for the Extension of Medical Service was formed in Trenton on December 7 at a meeting attended by twenty-five subscribers to the National Physicians' Committee. Also present as guests were: DR. THOMAS K. LEWIS, President of The Medical Society of New Jersey; DR. LEROY A. WILKES, Executive Officer; DR. HENRY A. DAVIDSON, Editor of *The Journal*, and DR. F. F. BORZELL, Past-President of the Medical Society of the State of Pennsylvania.

The meeting was called by DR. WILLIAM J. CARRINGTON, a member of the National Board of Trustees of the National Physicians' Committee, and a Fellow of The Medical Society of New Jersey.

Dr. Borzell suggested that recent events made it necessary to extend the work of the National Physicians' Committee, and introduced MR. JOHN M. PRATT, Executive Administrator of the Committee. He characterized Mr. Pratt as especially fitted to carry on an educational program because of his training in newspaper and administrative work. Dr. Borzell regretted that doctors had to "stoop" to publicity techniques which a few years ago would have been thought beneath their dignity, and pointed out that we could do so because this was a campaign for the integrity of American medicine.

MR. PRATT explained why this additional program is being carried on by a separate organization rather than by the American Medical Association. One reason was a need for speedy action which the formalities necessary to a very large democratic organization would make difficult. The fact that the leaders of the A. M. A. were at the time under indictment by the Federal Grand Jury also made it unwise for the Association to plunge into an extensive public relations program.

The National Physicians' Committee was described as being totally non-partisan. However, the problem which it was seeking to solve had political aspects in the sense that it concerned legislative decisions. To combat any effort to cheapen the quality or socialize the operation of medical care is, in a sense, a political effort, but never a partisan one.

Mr. Pratt pointed out that within the Administration at Washington were many leaders who realized the importance of preserving a free and unregimented system of medical care and that it was our duty to supply these supporters with the evidence of the soundness of their stand.

The importance of education as a counterweight to propaganda was stressed. The National Physicians' Committee was set up to promote public education in this field. Leaders of the A. M. A. have, in general, and acting as individuals, endorsed the program. These projects cost money and in order to mobilize the available financial resources

it was considered advisable to secure funds from interested friends and individual doctors.

Another job was to explain to the public and to the Government the fuller implications of the Wagner Bill. It was also necessary to unify medicine itself in an understanding of the meaning of this Bill. A fourth job was to give the public some idea as to what American medicine had done for them.

The National Physicians' Committee has refused to approach this by lobbying or by applying any direct pressure to Congressmen or Senators. Instead they carry the message to the public. One technique was to dramatize the achievements of American medicine—for example, the lower death rate, the extended life expectancy, and the maintenance of the best health rate in the history of the country. These were publicized by advertisements in newspapers all over the country, by notices in national magazines, by local radio programs and by addresses to civic organizations.

Mr. Pratt felt that the present war emergency had improved the position of organized medicine because the A. M. A. was rendering such a magnificent service to National Defense. However, he said that the menace of compulsory health insurance still faced us and could be defeated only by united action.

DR. LEWIS pointed out that in New Jersey we had sought to protect public health by transmitting to legislators our opinions on health legislation and our reasons for these opinions. We do not "lobby". We are available to advise legislators and we approach the public by means of a carefully planned public relations program. Dr. Lewis then described the Medical Service Administration as an example of an affirmative effort to balance state medicine propaganda.

DR. LEWIS explained why The Medical Society of New Jersey was reluctant to take a definite position in reference to the National Physicians' Committee. Some members of The Medical Society felt that the A. M. A. should have enlarged its functions to embrace the educational work of the N. P. C. He explained that as an official body we can neither approve nor disapprove of this group, and that the only body empowered here to endorse or disapprove of the N. P. C. is the House of Delegates. Doctors who thought that the Society should take a record stand were urged to present the matter for consideration to the House of Delegates in April.

DR. FREDERIC W. LATHROP asked whether the National Physicians' Committee was interested in experimental attempts at medically controlled voluntary health insurance projects.

MR. PRATT answered that it was, and had studied and fostered many such plans.

DR. WILLIAM HERRMAN felt that the functions of the N. P. C. were clearly within the proper scope of the A. M. A., since the latter organization is recognized by the public as the one official organization of the American doctors.

DR. CHESTER ULMER presented the following resolution:

*Whereas*, Rapidly changing conditions have created and are creating new problems that demand solution by the medical profession; and

*Whereas*, The National Physicians' Committee for the Extension of Medical Service has demonstrated the soundness of its policy and the effectiveness of its program; and

*Whereas*, The wartime needs and the post war reconstruction will create an even greater field of usefulness for such an independent medical agency as that of the National Physicians' Committee;

*Therefore, Be It Resolved*, That we hereby express approval of the National Physicians' Committee for the Extension of Medical Service; commend it for its sane and constructive program of public education; and pledge our moral and finan-

cial support to make possible its continued operation on a basis of increased activity and even greater effectiveness.

This resolution was passed by the unanimous vote of the subscribers present, the guests taking no part in the voting.

A motion was then made by Dr. Ulmer that there be organized in New Jersey a local committee affiliated with the National Physicians' Committee. This was seconded and passed. DR. ARTHUR W. BINGHAM then moved that the charter members of the New Jersey Physicians' Committee be: CHESTER I. ULMER, Gibbstown, Chairman; V. EARL JOHNSON, Atlantic City; O. R. HOLTERS, Asbury Park; ARTHUR F. ACKERMAN, Summit; GEORGE N. J. SOMMER, Trenton; JOHN F. WEBER, South Amboy; THEODORE ROBIE, East Orange; J. EDWIN OBERT, New Egypt, and FREDERIC W. LATHROP, Plainfield.

Dr. William J. Carrington, a member of the National Board of Trustees, was designated as the liaison officer between the National Physicians' Committee and its New Jersey affiliate.

## DISPLAY OF VASCULAR MANIKIN

A life-sized glass woman, illustrating the vascular system, has been purchased for the Newark Museum with funds given by Louis Bamberger. The only one of its kind in the world, the museum's new display is etched on a large sheet of plateglass behind which an intricate arrangement of lucite tubes, light bulbs and synchronized mechanisms produce the effect of blood flowing through the principal veins and arteries. The bloodstream effect is produced by glass bars wrapped spirally with black tape in the manner of a barber's pole. Each bar rotates before a powerful tubular bulb, casting light on individual pieces of lucite which in turn carry the light to the front of the model. As the taped portion of the turning bars blocks the light from each piece of lucite in turn, the effect of movement is created.

The vessels are colored so that the blood appears red as it flows from the heart and blue as it returns. The model also has a realistic heart which throbs at 72 beats a minute. A faint ticking noise produced by the synchronized mechanism lends another note of realism. The museum is at 43 Washington Street, Newark.

## PRESENT STATUS OF PNEUMONIA THERAPY

Since the introduction of sulfanilamid and the elaboration of its derivatives, the treatment of pneumonia has undergone radical changes and, in some measure, has been simplified.

However, it cannot be too strongly emphasized that *the safe, satisfactory and efficient treatment of pneumonia cannot be regarded as simplified or standardized to the point where it consists solely of the administration of pills.*

Pneumonia is still a serious disease and every case of pneumonia is still an individual problem.

Sulfanilamid derivatives are of great value, but they must be regarded as adjuncts to the treatment rather than as the sole agents in pneumonia therapy.

While these drugs may be used in all cases, they are not equally effective in all. In certain cases, and under certain circumstances they must be reinforced by serum therapy and in some instances, serum therapy will be the important, perhaps the sole, means of effective treatment.

It is of the utmost importance, therefore, that there shall be available for the successful progress of a pneumonia campaign therapeutic serum, and typing serum for the determination of the type of infecting pneumococci as well as the sulfanilamid group of drugs.

To what extent either or both will be used will depend upon the individual case and the individual circumstances but *both serum and the sulfanilamid drugs must be available.*

R. A. KILDUFFE, M.D.



## DR. PROUT HONORED

The fall meeting of the Summit Medical Society was a dinner at the Beechwood Hotel, October 28, in honor of Dr. THOMAS P. PROUT, of Fair Oaks Sanatorium. The occasion commemorated his fifty years in practice. The dinner was attended by forty-three members and seven guests, including his old friend, Dr. CHRISTOPHER BELING of Newark; REV. KINSOLVING of Summit and Dr. G. V. BURBECK of Caldwell.

Dr. Prout was born in Ashland, New York, in 1867 and entered the College of Physicians and Surgeons of Columbia University in 1891. He interned at St. Joseph's Hospital, Paterson, N. J., and then went to Greystone Park where he established one of the first of the three neuropathologic laboratories in the United States. He served a clerkship in the London Hospital of Queen's Square and then went to Vienna where he continued his studies in neuropathology under Dr. Marburg. On his return to the United States he worked at the Vanderbilt Clinic where he was associated with Dr. Starrs. In 1902 he established, with Dr. Gorton, Fair Oaks Sanatorium in Summit, N. J.

He is a member of the New York Neurological Society, the New York Academy of Medicine, the New York Psychiatric Society and the New Jersey Neuropsychiatric Association. He is a member of the American Medical Association and The Medical Society of New Jersey. Dr. Prout is in the Founders Group of the American Board of Psychiatry and is one of the founders of the Academy of Medi-



cine of Northern New Jersey. In 1905 he was a founder member of the Summit Medical Society. He is Consulting Neuropsychiatrist at Orange Memorial Hospital, Elizabeth General Hospital and Overlook Hospital in Summit, N. J. Dr. Prout is an active member of the Sterilization League of New Jersey.

Dr. Prout has contributed several articles\* on neuropsychiatry to the literature and was awarded, with Dr. L. P. Clark, 1903, the Stevens Triennial Prize for his work on epilepsy.

At the dinner, Dr. Beling spoke of his forty years' association with Dr. Prout and Dr. R. D. Baker. Dr. William H. Lawrence, Charles S. Hardy, D.D.S.; Dr. C. B. Keeney and Rev. W. O. Kinsolving all spoke in commendatory fashion of his life and professional activities.

Dr. Bowles presented to him a plaque from the Summit Medical Society in honor of this half century of practice.

## MAINTAINING INSULIN QUALITY

The Board of Trustees of the United States Pharmacopoeia has given special consideration to the expiration of patents on insulin which occurred in December, 1941. Heretofore all insulin in the United States has been subjected to standardization and assay both by American manufacturers and by the Insulin Commission of the University of Toronto which holds the patents. The Board of Trustees has recommended that standards and assays for insulin be made available so that the Food and Drug Administration may apply the new Pharmacopoeial standards immediately.

Because of the special nature of insulin which makes it a matter of life or death that the product be fully efficient in the dosage prescribed, and never of less nor of greater strength, it is proposed that the two-assay control which now prevails under the insulin pat-

ents be continued, and that the Food and Drug Administration do not release for general sale or distribution any insulin, until it is assured that the product meets the standards and assays which the United States Pharmacopoeia specifies.

Already several foreign manufacturers have shipped insulin to the United States with a view to its distribution as soon as the patents expire. Such insulin, and all other insulin, will be controlled by the action taken by the Board of Trustees and Committee of Revision of the Pharmacopoeia, cooperating with the Food and Drug Administration. The million diabetics in this country will thus be protected against the possibility of using inefficient or toxic insulin.

\* Most recent of which appeared in the December 1941 *Journal*, page 647.



## ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The Academy of Medicine offers the following scientific sessions in January. These meetings—all of which are held at the Academy's building, 91 Lincoln Park, Newark—are open to all members of the medical profession.

*Monday, January 12:* Eye, Ear, Nose and Throat Section. 8:45 p. m.

- (a) "The Practical Value of Aniseikonia", an illustrated talk by HERMANN M. BURIAN, Ophthalmologist-in-Chief to the Dartmouth Eye Institute.
- (b) "Language Disability and Unilateral Dominance", by LEWIS H. LOESER, M.D.

*Tuesday, January 13:* Section on Medicine and Pediatrics. 8:45 p. m.

"Pneumococcic Pneumonia: Prognosis; Selection and Control of Treatment by Sputum Studies"; an illustrated talk by ARTHUR

W. FRISCH, M.D., Assistant Professor of Bacteriology at Wayne University.

*Thursday, January 15:* Stated meeting of the Academy under auspices of the Section on Surgery. 8:45 p. m.

"Gastric Ulceration and Early Cancer of the Stomach"; an illustrated talk by ARTHUR W. ALLEN, M.D., Chief of Surgical Service, Massachusetts General Hospital.

*Friday, January 23:* At 4:30 p. m., a one-hour program of moving pictures, sponsored by the Committee on Public Health and Medical Education of the Academy of Medicine. Two films:

- (a) "A Clinic on Acute Mastoiditis."
- (b) "Suppurative Petrositis with Meningeal Symptoms, Operations and Recovery."

Films prepared by SAMUEL J. KOPETZKY, M.D., and RALPH ALMOUR, M.D., and released through the New York Medical Film Guild and the Doho Chemical Corporation.

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## IMPROVEMENT IN SCHOOL MEDICAL SERVICE



Dr. Philip Van Ingen has given valuable pediatric leadership as Chairman of the Advisory Committee of the "Astoria School Health Study", which should influence the thinking and lead to changes in practice throughout the country. This study has already caused far-reaching changes in our largest city. The "administrative research" methods used in analyzing the service and in making the changes point the way for new developments in the future. The report which will soon be published interprets all the changes which we have cited as new trends and suggests many other improvements in harmony with medical thinking that will have application throughout the country. Dr. Van Ingen has described these "new objectives" and "new and better practices" as aiming at "an effective utilization of organized effort for the better health of school children". In the opinion of the Chairman, who has reviewed the preliminary text, it offers the best guide available for directing school health programs according to the philosophy expressed in the reports of this Committee and

according to sound principles of education and medical service.

The trend towards medical guidance, consultation and a more comprehensive understanding of the whole child through the sharing of information by all who work with him has been well expressed by Benjamin Spock, M.D., in "The Changing Task of the School Physician". This series of articles appearing in "Progressive Education" give a stimulating interpretation of what is meant by medical guidance and consultation and the possibilities of health supervision through the school without assuming responsibilities that are not the function of the school medical service.

As the work of the physician does not accomplish very much in the average public school situation without the assistance of the well-qualified nurse, it is worthwhile for pediatricians who would exert influence on school health practices to study the 1940 Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association;—"The Nurse in the School, an Interpretation".

## TRAFFIC ACCIDENTS COMMITTEE

Under the chairmanship of Dr. M. F. Sewall, the Committee on Traffic Accidents met at the Executive Offices in Trenton on December 14. The Committee urged doctors to register as accurately as possible, the number of patients in their records who were suffering from pathologic disorders which might interfere with the alert operation of motor vehicles. In particular, doctors were asked to tabulate patients suffering from cardio-renal, hypertensive, convulsive, visual and psychiatric disorders.

It is understood that doctors will not be asked to give the names and addresses of those patients, but to supply this information for statistical purposes only. The Society wants to know approximately how many men and women are now driving cars in this state who are potential risks by reason of physical or mental disorders, and it is hoped that such information may be secured if all the doctors in New Jersey will coöperate by supplying the basic statistical data.

## PHYSICIANS' HEALTH AND ACCIDENT INSURANCE

The National Casualty Company announces a reduction in rates in the Physicians Special Policy issued to members of The Medical Society of New Jersey. The rate reduction was effective on January 1, 1942, and amounts to about 5 per cent for men in the age group 51-60, and about 27 per cent in the age bracket 61-65. Thus the premium for a monthly benefit of \$100.00 has been reduced from \$38.00

to \$36.40 a year for men between 51 and 60, and from \$65.00 to \$51.50 a year for men between 61 and 65. Other premium rates for these age groups have been reduced in proportion.

The new non-cancellable rider will be put into effect when the Company secures subscriptions from 50 per cent of the members of the local component societies.

## OBITUARIES

### JAMES P. MORRILL

Impressive funeral services were held on December 16 for Dr. James P. Morrill, Sr., one of Paterson's leading surgeons and head of the orthopedic ward of St. Joseph's Hospital, who died December 14 following an illness of seven months. A hundred of his associates in the medical world joined to pay final tribute to Dr. Morrill at the rites held at his home, 310 Broadway, Paterson. The Rev. Dr. Robert R. Bryan, pastor of the Church of the Messiah, officiated and burial was made on December 18 in Hamburg, Connecticut, under the direction of the Robert C. Moore and Sons Home for Funerals.

Dr. Morrill, who was 65, was the husband of the former Miss Ethel Martin.

He was a member of the American College of Surgery, the Passaic County Medical Society, the Alumni of the Hospital for Ruptured and Crippled

of New York City, the Association of the Yale Alumni of Medicine and the Society of the Surgeons of New Jersey.

### DR. THEODORE H. LEMMERZ

Dr. Theodore H. Lemmerz died November 8, 1941, at his home in Jersey City.

Dr. Lemmerz was born in New York City, in 1870. He received his preliminary education in the local Jersey City schools and at Drake's Business College, and received his medical degree at the New York Homeopathic Medical College in 1896. Dr. Lemmerz specialized in ailments of the eye, ear, nose and throat.

He was a member of The Medical Society of New Jersey, Hudson County Medical Society, and a Fellow of the American College of Surgeons.

## ACHIEVEMENT IS THE YARDSTICK

Mrs. Gertrude Springer, Associate Editor of *Survey* and principal speaker at the Welfare Council's Annual Meeting on November 14th, 1941, in Asbury Park, emphasized delightfully and convincingly three points:

1. That democracy is the result of work, not words.
2. That the workers themselves in their daily job must be capable and effective and not too dog-

matic because the opinion of the public is based upon actual benefits received through service.

3. That "background" and "preparation" for the job must be justified through successful operation and achievement on the job.

Her message was clear and applies equally to physicians and others. I believe we will endorse these sentiments most enthusiastically.

LEROY A. WILKES, Executive Officer,  
The Medical Society of New Jersey.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

At the December 12 meeting of the *Atlantic County Medical Society* announcement was made that DR. ROBERT A. KILDUFFE (Pathologist to the Atlantic City Hospital) had been honored by appointment as Deputy Chief of the Coastal Zone Area, under the State Civilian Defense Program. His will be a very responsible and important position in civilian defense as Chief of the Local Emergency Medical Service. He outlined the important steps to be made in formulating local plans under the supervision of the state and national committees. A committee will be appointed to act with Dr. Kilduffe in an advisory capacity and to complete all emergency medical relief plans. The importance of decentralization of the work was stressed, and the full coöperation of the doctors was asked for.

Dr. Perry Frank, Dr. John H. Mathis and Dr. Caesar Milano were approved by the Board of Censors for membership in the Atlantic County Medical Society.

DR. HARRY SUBIN, President of the Society, introduced the speaker of the evening, DR. TRACY JACKSON PUTNAM, Professor of Neurology and Neurosurgery, College of Physicians and Surgeons, Columbia University. He described the nature and history of epilepsy and cited many men in history, such as Caesar and Napoleon, who had suffered with it. He spoke of epilepsy as of great economic importance because it prevents people from working and holding a normal place in society. However, it seems now to be a hopeful problem for the new treatment with dilantin has been 80 per cent successful if properly administered.

The County Society recommended to The Medical Society of New Jersey the election of DR. HILTON READ as Second Vice-President of that organization.

### BERGEN COUNTY

Samuel C. Bump, M.D., Reporter

The October 14 meeting of the *Bergen County Medical Society* was held at Bergen Pines, and the first speaker was DR. JOSEPH MORROW, Medical Director of that institution. He opened a symposium on "Anterior Poliomyelitis", and was followed by DR. D. F. REILLY of his staff, who reviewed the cases admitted during 1941. The neurologic aspects were discussed by DR. NELSON POLICASTRO, Chairman of the Mental Hygiene Committee of Bergen County. The symposium was continued by DR. FREDERICK DILGER, Chairman of the Orthopedic Committee, who gave a brief talk on rehabilitation in poliomyelitis.

The essayist of the evening was DR. PHILLIP N. STIMSON, Assistant Professor of Pediatrics, Cornell University, who reviewed all aspects of the problem, including the much-discussed "relaxation treatment" of Sister Kenny.

Dr. F. Dean Roylance, Closter, and Dr. Olaf J. Severud, Hackensack, were elected to membership.

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at Moorestown December 12, 1941.

DR. DEAN LEFAVOR called the meeting to order and welcomed DR. PAUL MECRAY, JR., of Camden County and DR. HENRY DIVERTY and DR. B. A. WOOD of Gloucester County and the HONORABLE MATLACK STACKHOUSE, Assemblyman of Burlington County.

DR. FREEMAN METZER introduced DR. WAYNE BABCOCK, Professor of Surgery of Temple University, whose topic was "Intestinal Malignancy". Dr. Babcock said that the symptoms of gastric carcinoma were similar to peptic ulcer. Bowel carcinoma is more frequent in males than in females and occurs usually in middle life. In diagnosing gastro-intestinal malignancy, all methods are employed. He stressed the fact that many physicians forget to palpate the rectum with the finger. Briefly, Dr. Babcock described his surgical procedures. His lecture was illustrated with many excellent colored photographs.

DR. WARREN RODMAN asked physicians to volunteer their services as instructors in first aid. Any physicians willing to participate in this important program should communicate with Mr. Gerry Yentzer of Burlington, N. J.

DR. JOSEPH KUDER introduced Assemblyman Matlack Stackhouse, who brought up for discussion the Sterilization Bill, which is to be considered by the Senate and Assembly of New Jersey. DR. EMLEN STOKES explained the bill and led the discussion which followed. The bill was approved by the County Society.

### CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

DR. A. L. STONE presided at the meeting of the *Camden County Medical Society* on November 4th, 1941.

An interesting paper on the "Management of Anemia in General Practice" was presented by DR. THOMAS FITZ-HUGH, JR. Dr. Fitz-Hugh's paper was discussed by Drs. Kerdasha, Gilbert, Shull, Sharp and Goldstein.

The Board of Censors and the Membership Committee approved for active membership: Robert A. Cooper, M.D., Merchantville; Ernest E. Manser, M.D., Collingswood; Edward Shaen, M.D., Fort Dix; W. J. Snape, M.D., Runnemede; Edward G. Osborn, M.D., Camden; Benjamin F. Lee, M.D., Camden.

The Graduate Course in Medicine was called to the attention of the members by DR. DAVID BENTLEY, JR. The next lecture, presented by DR. RANDLE C. ROSENBERGER, Professor of Preventive Medicine and Bacteriology, at Jefferson Medical College, will be on "Virus and Virus Infections".



**CUMBERLAND COUNTY**

E. C. Lyon, M.D., Reporter

The December 9 meeting of the *Cumberland County Medical Society* was held in the House of Friendship, Millville. DR. LEONARD SCOTT of Bridge-ton was admitted into membership by ballot.

DR. CHARLES BUTCHER reported the progress of a special meeting held in Trenton, November 9, to discuss the Medical Service Administration.

The scientific program was presented by DR. MITCHELL RUBIN, Associate Professor of Pediatrics in the University of Pennsylvania. His subject was the "Newborn Child". He stated that "to decrease infant mortality we now have to deal with infants of the first month. The main causes of death are: Premature birth, 50 per cent; birth injuries, 13 per cent; malformations, 10 per cent; respiratory diseases, 5 per cent.

"Research has shown that new babies have a high hemoglobin percentage and large red cells. Toxic mothers give birth to sick babies who are low in weight and low in hemoglobin. Premature babies are severely affected by a prolonged gas anesthesia of the mother. Hemorrhages of the new-born are being controlled by prenatal doses of vitamin K given during the preceding month.

"Premature babies with a high temperature stand a much better chance of survival than low temperature babies. The air in the nursery should be kept moist instead of dry. Toxic diarrhea of infancy should be checked early by fluids, saline injections and sulfathiazole."

**GLOUCESTER COUNTY**

Clarence A. Bowersox, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held December 18, 1941, at the Woodbury Country Club.

MR. NICHOLSON of the Woodbury Old Age Pension told members that the minimum age for assistance was to be 60. The present plan gives each pensioner \$30 per month, which is now quite unsatisfactory. New plans are to be adopted in the future.

DR. HOBART A. REIMANN, Professor of Medicine at Jefferson Medical College, opened the scientific part of the meeting with his talk "Respiratory Diseases and Their Modern Management". The etiologic diagnosis in lobar pneumonia must always be made. The types of pneumonia as related to treatment by chemotherapy are subdivided as follows:

**PNEUMOCOCCIC TYPES**

Mortality since the event of chemotherapy has dropped to 5 per cent. The types of pneumonia that respond best are Types I, II, III, V, VII, VIII, XIV. The treatment divides itself as follows, in order of importance: Before therapy is instituted, a complete blood count, blood culture and sputum examination are performed. An x-ray of the chest is sometimes necessary. Sulfa-diazin is then given in an initial dose of 4 grams. Two grams are then given every four hours, day and night. A soluble salt such as sodium sulfothiazole is now prepared to be given intravenously in the severe types. Serum is used only when there is toxicity as a result of chemotherapy. The occasional patient who

does not respond to chemotherapy must take serum. One hundred thousand units of serum are necessary as an initial dose.

**ATYPICAL PNEUMONIA**

Cases in which chemotherapy is not clearly indicated constituted two-thirds of the patients in the past winter. Pneumococci are rarely found in the sputum. These pneumococci usually are of the higher types and are found in large amounts in the blood stream. Some of the doubtful types are also in the hemolytic streptococci and staphylococci pneumonias.

Those pneumonias in which chemotherapy is not indicated include a large number of generalized respiratory infections occurring in the winter months in epidemic form. Many of the patients are not even sick enough to go to bed and only 3 per cent develop pneumonia of the bronchial type.

**MEDICAL PREPAREDNESS COMMITTEE**

DR. WILLIAM PEDRICK presented a plan of action for medical defense to the society. The society readily approved this action. It was noted that first aid instructors are greatly needed in several parts of the county. Steps were taken to overcome this difficulty. It was also suggested that the three draft boards of Gloucester County be united as one and perform their duties in one group at one specific time and place.

**MERCER COUNTY**

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in annual session December 10 for the election of officers.

DR. LEROY A. WILKES, Executive Officer, addressed the Society on "Planned Essentials", emphasizing the necessity of providing medical care for the group lacking the intelligence or initiative to seek medical aid, and who cannot, or will not, pay a share toward the cost.

DR. NORMAN M. SCOTT, Medical Director of the Medical Service Administration, read the resolutions which The Medical Society of New Jersey had adopted relative to Medical Service Administration.

The outstanding essentials, demonstrated by facts and figures obtained from an exhaustive survey by the committee appointed for this purpose were thoroughly discussed.

DR. L. S. SICA, Chairman of the Mercer County Advisory Committee to the Medical Service Administration, moved the adoption of the resolution. This motion was seconded and carried.

DR. HARRY R. NORTH, treasurer, then submitted his annual report, Drs. Haggerty, Wikoff and Scammell being appointed auditors. They reported that the books and accounts of the treasurer were found to be correct in every detail.

DR. JOHN H. McCULLOUGH, Chief of Local Defense, gave an interesting resume of the provisions under process of final organization, embodied in the scheme of the Defense Plan. The Society approved the appointment of Dr. Harold C. Cox and Dr. J. H. McCullough as Chairmen of Health and First Aid Committees.

The application of DR. A. E. OGDEN for Active

Membership was read and referred to the Committee on Membership. On recommendation of that Committee, DR. DANIEL BERGSMAN, DR. HENRY AUSTIN and DR. E. P. SACKS-WILNER were promoted to Active Membership, while DRs. JOSEPH COHEN, G. E. MARK, E. G. ROWLAND and J. G. WILSON were elected to Associate Membership.

Announcement was made of the resignation of DR. ADA WRIGHT, who has left the State Home for Girls to join the Columbus (Ohio) Academy of Medicine.

The following officers were nominated and elected:

DR. SAMUEL BLAUGRUND, President  
DR. J. I. WIKOFF, President-Elect  
DR. A. D. HUTCHINSON, Secretary  
DR. HARRY NORTH, Treasurer

Designated as delegates to The Medical Society of New Jersey were: Drs. Beirsto, Blaugrund, D'Arcy, Haggerty and Haney. Drs. Burns, Applestein and Nonziato were made members of the Executive Committee, and Drs. Williams, Burroughs and Ivins of the Finance Committee.

The alternate delegates elected were Drs. Cottle, Davenport, Stein, Stone and Zimskind.

#### MIDDLESEX COUNTY

Cyril I. Hutner, M.D., Reporter

The November session of the *Middlesex County Medical Society* was a joint meeting with the Middlesex County Pharmaceutical Association, one hundred physicians being the dinner guests of the pharmacists at the Colonia Country Club, Colonia, N. J., on November 26, 1941. Cocktails were served at 8 p.m. and dinner at nine o'clock.

The meeting was called to order by the HONORABLE WILLIAM F. SMITH, toastmaster. Speakers of the evening were: DR. R. J. FAULKINGHAM, President of the County Medical Society, and DR. THOMAS K. LEWIS of Camden, President of The Medical Society of New Jersey, representing the physicians; MR. JOHN HOAGLAND, President of the County Pharmaceutical Association, and DR. ROBERT P. FISCHER of Trenton, First Vice-President of the New Jersey Pharmaceutical Association, representing the pharmacists. Guest speaker was the REV. DR. SAMUEL STEINMETZ, Rector of St. Michael's Episcopal Church, Trenton. He delivered an excellent and well-received talk.

Approximately 175 physicians and pharmacists attended the affair, which was a huge success.

During a brief business session the following Associate Members were elected to regular membership:

Dr. C. E. Lewis, New Brunswick  
Dr. Sydney Smith, Highland Park

Dr. Maurice Landau, formerly of Fords, was granted permission to transfer his Associate Membership to the Monroe County Medical Society, Rochester, N. Y., where he is now in practice.

The meeting was adjourned at 11:40 p.m.

#### MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The Monmouth Memorial Hospital was host to the *Monmouth County Medical Society* at its regu-

lar meeting on November 26, 1941, at 9 p.m. It was held in the new auditorium of the Borden Memorial Pavilion of the Monmouth Memorial Hospital. MR. BERTRAM BORDEN, donor of the building, was present.

MRS. GRUNAU, representing the American Red Cross, gave an interesting historical background of the Red Cross and explained its present composition.

The speaker of the evening was DR. A. HARRY NEFFSON of New York City, who talked on "The Management of Laryngotracheobronchitis from the Pediatric and Laryngologic Viewpoint". The paper was unusual. The speaker gave a first-hand, authoritative, instructive talk on the subject. He had spent three years on the Laryngologic Service at Willard Parker, which gave him a rich background for the subject.

#### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

The second of our series of six Post-Graduate Lectures was attended by nearly a hundred members and guests on December 18, 1941, at the New Jersey State Hospital, Greystone Park, DR. DANIEL TELLER presiding.

It was unanimously voted that the Society purchase a \$500 Defense Bond, as recommended by the Executive Committee. Members also expressed a desire to cooperate with the Nurses' Aid Class. Volunteers to teach the American Red Cross First Aid classes were requested to report to Drs. Crandell, Blanchard and Williams in their respective areas.

DR. RUTH EARP, our efficient Post-Graduate Education Committee Chairman, introduced our guest speaker, PHILIP M. STIMSON, M.D., Assistant Professor of Clinical Pediatrics, Cornell University Medical College; Associate Attending Pediatrician, New York Hospital; Attending Physician, Willard Parker Hospital, New York, who held our interest in a discussion of "The Diagnosis and Early Treatment of Poliomyelitis".

To illustrate posture, muscle actions and other important details, a student nurse, who volunteered as a live model, was used, together with bed, boards, splints and sand bags and other apparatus.

Dr. Stimson stressed the importance of early recognition of the disease, and immediate rest in bed, thereby increasing the chance of preventing disabling paralysis, and also in epidemics to avoid swimming, because of danger of contaminated waters, and to avoid fatigue and exhaustion and chill, lowering resistance, and to particularly respect any minor illness which possibly might be polio, in such instances to place them in bed immediately.

We were particularly intrigued by his discussion of Sister Kenny's treatment. Sister Kenny recently visited New York, and that there appears no question but that she has made a valuable contribution to the management of early poliomyelitis. Dr. Stimson has deduced that the patients are much more comfortable with the decrease in painful spasm, the result of the hot, wet packs and passive motion short of fatigue, and relieved to find that the muscles are usable. Certainly they have not been



harmcd so far, and the usual complications are avoided. Whether there will be less residual paralysis remains to be seen.

By these procedures the use of the standard splints has been avoided and now appear a thing of the past, except for transportation of an afflicted patient.

### PASSAIC COUNTY

I. Okin, M.D., Reporter

The monthly meeting of the *Passaic County Medical Society* was held at the Valley View Sanatorium, Preakness, on December 11, DR. SIGURD W. JOHNSEN presiding.

Dr. Johnsen announced a change in defense plans, reporting that the entire program was now under the jurisdiction of the New Jersey State Defense Council and that each mayor appointed the Chief Medical Officer who would organize the medical aspect of civil defense. The County and State Society were now acting in an advisory capacity.

DR. FRANK VISCEGLIA of Passaic was elected to active membership, and DR. JOHN R. P. FENWICK of Clifton to associate membership.

Four applications for active membership and one for associate membership were read as having been received.

### SCIENTIFIC PROGRAM

1. Some Problems in the Diagnosis and Care of Early Tuberculosis were presented by DR. F. MAURICE MCPHEDRAN, Director of the Research Department of Respiratory Diseases, Germantown Hospital, Philadelphia. The speaker pointed out that tuberculosis increases during war-time and that in England an increase had already been noted.

He emphasized the problems of diagnosis at this time. In children chronic bronchopneumonia is often the cause of cough and disability. These infections showed in the x-ray (particularly at the base of the lung and the cardio-phrenic angle). Infections of the base of the lung in children do not develop into tuberculosis at the apex. He showed many films illustrating these conditions.

2. County Tuberculosis Clinic Service, presented by DR. WILLIAM GROSFELD. This was a summary of the examinations done by the Valley View Sanatorium Clinic Service and out of 26,839 case patients examined, 1,364 cases of tuberculosis were discovered. This included the examination of children in grammar school, high school, student nurses, Negroes, WPA, relief clients, old age indigents, low income groups and personnel at the Sanatorium.

3. Sterilization of Staphylococcus Pleural Empyema with Sodium Sulphathiazole, presented by DR. HOMER H. CHERRY. The speaker reported three cases of empyema with tuberculous infections. It had been cleared up by the use of installations of sodium sulphathiazole in the chest cavities.

4. Tuberculosis Committee, reported by DR. MORRIS JOSEPH, Chairman. The committee made the following recommendations:

A. That the County Medical Society recommend to labor and employers that overtime in industries be eliminated to cut down tuberculosis. The committee does not mean the elimination of three shifts

a day but it would advise abandonment of the practice of having men working 10 or 12 hours a day.

B. That all people in the lower income group be advised to have x-rays of their chests taken at the clinic. A large number of cases is found in this group. Firms and corporations should request fluoroscopic examinations for all applicants for employment in order to prevent the breakdown of many of these employees after they have been working. Dr. Joseph also reported that in the event of a major catastrophe the Valley View Sanatorium had accommodations for 100 patients with nursing and proper medical care.

The meeting then adjourned. An excellent collation was served following the meeting.

### SALEM COUNTY

Lee C. Hummel, M.D., Reporter

An increasing interest in our society meetings was demonstrated on November 14th when twenty-three of our twenty-nine members attended the meeting of the *Salem County Medical Society*.

DR. E. E. EVANS presided and opened the meeting promptly at 4 p.m. During the short business session a motion was passed inviting members from other county societies, who at present are connected with industries in our county, to become associate members during their stay here.

DR. DAVID W. GREEN made a report from the Welfare Committee.

The scientific program consisted of a talk by DR. H. P. SHIPPS of Camden, N. J., on "Office Gynecology". He presented the subject very ably, covering the many points that continually confront the general practitioner. Diagnosis, treatment and new techniques in the handling of the gynecologic patient were presented in such a way as to make a very practical and worthwhile paper.

Discussion was opened by DR. W. T. HILLIARD and entered into by several of the other members.

A turkey dinner was served following the meeting.

### SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at the Overlook Hospital on November 25th with DR. STEUART, the President, presiding. There were twenty-four members and seven guests present.

DR. WATSON B. MORRIS presented slides with discussion of "175 Years of Medical Practice in New Jersey". This was followed by colored motion pictures which Dr. Morris had taken, with an elaborate and excellent portrayal of "The Tour of the International College of Surgeons to Mexico" this past August.

The following officers were elected for the coming year:

DR. D. F. STEUART, President

DR. M. C. SMALLEY, Vice-President

DR. E. H. MACPHERSON, Secretary

Entertainment Committee: DR. ROBERT M. MILLER and DR. NORMAN L. MURRAY



# WOMAN'S AUXILIARY

## WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Chairman Press and Publicity

### COMING EVENTS

#### ATLANTIC COUNTY

January 16, 1942, 8:45 p.m.

Speaker: Mrs. E. G. Shreve

Subject: The Work of the Public Health Service

Guest: Mrs. O. R. Carlander

#### BERGEN COUNTY

January 13, 1942, 9:00 p.m.

Hackensack Hospital, Hackensack

Speaker: Rev. Arthur Brown

Subject: Book Review

#### BURLINGTON COUNTY

February 2, 1942, 2:00 p.m.

Nurses' Home, Zurbrugg Hospital, Riverside

Tour of inspection, Zurbrugg Hospital

Tea

#### ESSEX COUNTY

January 26, 1942, 2:00 p.m.

Academy of Medicine, Newark

Speaker: Dr. F. Parker Willey

Subject: Mystery of Coronary Diseases

Tea

#### GLOUCESTER COUNTY

January 15, 1942, 9:00 p.m.

Woodbury Country Club, Woodbury

Speaker: Dr. H. L. Sinerson

Subject: Mexico

January 29, 1942

Residence: Mrs. C. A. Bowersox, 106 South

Columbia Street, Woodbury

Social evening, husbands invited

#### HUDSON COUNTY

February 2, 1942, 2:00 p.m.

Y. W. C. A., Fairmount Avenue, Jersey City

Speaker: Mr. David Armstrong, Head of the

English Department, Emerson High School

Subject: Book Review, "Keys of the Kingdom"

#### PASSAIC COUNTY

January 19, 1942, 3:00 p.m.

Paterson Women's Club, Paterson

Lecture: "Making the Most of Our Looks"

Tea for new members

#### UNION COUNTY

January 14, 1942, 9:00 p.m.

Muhlenberg Hospital

Lecture: Nutrition

Guest Night

#### WARREN COUNTY

January 20, 1942, 11:00 a.m.

Elks' Auditorium, Phillipsburg

## "E" Is for Essex County

These articles, written by the Presidents of the County Auxiliaries, are published each month and describe the procedures, aims and pet projects of the County Auxiliaries.

On March 9 the open meeting of the Executive Board of the State Auxiliary will be held in Newark. The Auxiliary to the Medical Society of Essex County hopes to have as guests many members of other county Auxiliaries. We trust that all who read this will consider this an invitation to attend. Through the generosity of Dr. and Mrs. Wells P. Eagleton of Newark, there was recently added to the Academy of Medicine of Northern New Jersey a new building. This means that in addition to holding our meetings at the Academy, we may now do so in our own rooms. A delightful meeting room and lounge are for the use of the Auxiliary members. Not to be forgotten is a stream-lined kitchen which holds the promise of many nice parties to come.

The Red Cross Roll Call for Essex County has just been completed. As is the usual custom, a booth was manned by members of the Auxiliary. This booth was responsible for getting 498 new memberships. The allotment of this district in the new war-time Red Cross

drive is large and Auxiliary members hope to assist in this work of raising money.

Members worked on the Community Chest drive and also on the sale of stamps for the Prevention of Tuberculosis League. Many are active on the local Defense Council.

Mrs. Frank Bien, program chairman of Essex County Auxiliary, has conceived and executed a new plan. Some of the programs of this county are social, general or non-medical. It has been arranged that whenever that is so, one of the program committee shall read a five-minute paper on a timely medical or health subject. The paper is to be written by a local physician. This was tried out with success at our last meeting.

We have filled in our questionnaires and are most anxious to assist in every way with the Medical Preparedness Program for New Jersey.

We are anxiously waiting to welcome you to Essex County on March 9.

MRS. EDWARD W. SPRAGUE,  
President, Essex County.

## THE BULLETIN

Renew your subscription to the National Bulletin or become a new member this year. Efficiency in Auxiliary work will depend largely on the use made of the Bulletin. Advancement in any organization is in direct relationship to the improvement of facilities for the exchange and interchange of facts, knowledge, information and the proper use of these facilities. All state and county officers are well informed members and all are subscribers to the Bulletin. Every member of our Auxiliary

should realize her responsibility to our official publication and be a reader of it.

Starting with the fall issue of the Bulletin, all programs of the departments of Hygeia, legislation, program and public relations of the National Auxiliary will be discussed. All information relative to home defense measures, nutritional education and Pan-American unity will be presented in the four issues of the Bulletin this year.

Send subscriptions to: Mrs. Samuel H. Jesurun, State Chairman, Bulletin, 613 High Street, Newark, N. J.

## PUBLIC RELATIONS

The new A. M. A. radio program is being dramatized every Saturday over Stations WEAf and KYW at 5:30 p. m. It is a splendid program and well worth listening to.

At this time I would again like to say *how important* it is for the County Auxiliaries to distribute the posters publicizing this radio program "Doctors at Work". The posters may be placed in doctors' waiting rooms, schools, libraries, Y. W.'s or any other suitable place where people congregate. Your State Chairman has 1,000 posters for distribution. Please let me know how many you will be able to place in your county.

This is a definite piece of Auxiliary work that all members may participate in. We have been asked by the Public Relations Committee of the Medical Society to do this and to do it now. As your chairman, I am asking for your cooperation.

May I again draw your attention to the material available from the Director of Public

Information. Mr. G. Stewart Brown, American Red Cross, Washington, D. C. The American Red Cross has a supply of special stories suited for women's groups; material on first aid, blood banks, war relief, accident prevention, etc. A story can be developed for you if you give them a question or an idea. For instance, if you should want to know something about classes for teaching mothers in the home "First Aid", they will prepare the material for you. Be specific when you write for material.

It has been suggested by the Public Relations Committee of The Medical Society of New Jersey that if you ask for material on rolling bandages, blood transfusions, locating prisoners of war, sending packages to soldiers or any other phase of Red Cross work, it would make an interesting paper to be read at Auxiliary meetings or even at lay club meetings.

Mrs. Don Agard Epler of Newark is Chairman of Public Relations of the Woman's Auxiliary to The Medical Society of New Jersey.

## COUNTY AUXILIARIES

### Atlantic County

Reported by Mrs. Louis Feinstein, Chairman

The Executive Board of the *Woman's Auxiliary to the Medical Society of Atlantic County* met at the home of Mrs. Morton Major on Monday, December 8, 1941. Mrs. Major presided at the meeting and Mrs. Wilson and Mrs. Stamps were co-hostesses. Mrs. Samuel Gorson reported on the huge success of the Sweepstakes Dance. Attending the board meeting were Mrs. M. Major, Mrs. D. B. Allman, Mrs. R. Stamps, Mrs. A. Krechmer, Mrs. E. Dyer, Mrs. Charles Hyman, Mrs. A. Rieck, Mrs. H. Subin, Mrs. H. Kline, Mrs. I. Beir, Mrs. V. E.

Johnson, Mrs. J. Mason, Mrs. W. Chalfont, Mrs. S. Gorson, Mrs. L. Wilson, Mrs. S. Salasin.

A Christmas party was held on the regular meeting night, December 12, 1941, at the home of Mrs. James H. Mason. Each member brought a white elephant package as well as a Christmas gift for the Betty Bacharach children. The Christmas spirit prevailed throughout the house with a large, comfortable fire in the fireplace adding warmth and delight to the setting. The tree was beautifully lighted and was resplendent with unusual decorations. Christmas carols were sung by the entire group accompanied by Miss Barbara Mason at the

piano. A variety of games led by Mrs. R. Stamps kept everyone in laughter and excitement. Mrs. Shreve dressed as Santa Claud added charm to our gathering and after gifts were exchanged a delicious repast was enjoyed to make a most complete and happy picture.

Those attending the party were Mrs. James H. Mason, Mrs. E. Shreve, Mrs. R. Stamps, Mrs. H. Subin, Mrs. D. B. Allman, Mrs. I. Shavelson, Mrs. Morton Major, Mrs. I. Beir, Mrs. H. Kline, Mrs. Samuel Salasin, Mrs. Blair Stewart, Mrs. D. W. Scanlan, Mrs. C. Brown, Mrs. L. Wilson, Mrs. M. Mally, Mrs. W. Chalfont, Mrs. M. Molitch, Mrs. P. Joy, Mrs. R. Bradley, Mrs. B. Holoman, Mrs. S. Winn, Mrs. S. Rosenblatt, Mrs. J. Mishler, Mrs. J. Poland, Mrs. Charles Hyman, Mrs. V. E. Johnson, Mrs. William J. Carrington, Mrs. Edward Dyer, Mrs. B. H. Timberlake, Mrs. Elena De Hellenbrandt, Mrs. J. Irvin, Mrs. Allan Rieck and Mrs. Louis Feinstein.

#### Bergen County

Mrs. P. A. Groff, Chairman of Press and Publicity  
The *Woman's Auxiliary to Bergen County Medical Society* donated twenty-five dollars to the annual Red Cross Fund at its regular meeting at the Hackensack Hospital on December 9.

Our guest speaker for the evening was Mrs. Oswald Carlander, our State President, who gave us a talk on the interesting highlights of the National Convention, which she attended.

Mrs. W. J. Timmerman of Saddle River provided the entertainment in a lecture with examples of her work in flower arrangements.

#### Essex County

Mrs. Frank S. Forte, Publicity Chairman  
The *Woman's Auxiliary to the Essex County Medical Society* held its regular meeting on Novem-

ber 17 at the Academy of Medicine, 91 Lincoln Park, Newark, with Mrs. Edward W. Sprague, the President, presiding. An Executive Board meeting was held at 12:30. Reports of the various chairmen were accepted.

Mrs. Frank Bien, Program Chairman, introduced the guest speaker, Dr. Winifred C. Cullis, C.B.E., Professor of Physiology at the University of London. Dr. Cullis is in this country representing Great Britain and gave an interesting talk on conditions in England, her topic being "Social Services Go to War".

Mrs. Oswald R. Carlander, President of the Woman's Auxiliary to The Medical Society of New Jersey, brought news from the national meeting.

At the close of the meeting tea was served. Mrs. Sidney Keller, Social Chairman, was in charge.

#### Gloucester County

Mrs. Clarence A. Bowersox, Public Relations, Press and Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* sponsored a benefit card party November 28 at the home of Mrs. B. A. Livengood of Woodbury. Proceeds were donated to the Gloucester County Red Cross.

On December 12 the Auxiliary held its Christmas Party at the home of Mrs. J. H. Underwood of Woodbury. Mrs. H. H. Clark gave her talk on "The Romance of Christmas Greens". Twenty members and guests were present.

The Boys' Chorus, under the direction of Miss Helen Klepfer, Musical Instructress at the Woodbury High School, sang Christmas carols. Gifts were exchanged and refreshments served.

## BOOKS RECEIVED FOR REVIEW

OCCUPATIONAL DISEASES, diagnosis, medicolegal aspects and treatment. By Rutherford T. Johnstone. Pp. 558. Philadelphia, W. B. Saunders Co. 1941. \$7.50.

NUTRITIONAL DEFICIENCIES, diagnosis and treatment. By John B. Youmans, A.B., M.S., M.D., assisted by E. White Patton, M.D. Pp. 385. 1941. \$5.00.

DISEASES OF WOMEN. By Harry Sturgeon Crossen, M.D., F.A.C.S., and Robert James Crossen, A.B., M.D. 9th ed. Pp. 948. St. Louis, C. V. Mosby Company. 1941. \$12.50.

INFANT NUTRITION; a textbook of infant feeding for students and practitioners of medicine. By William McKim Marriott, B.S., M.D. Revised by P. C. Jeans, A.B., M.D. 3d ed. Pp. 475. St. Louis, C. V. Mosby Company. 1941. \$5.50.

RHEUMATIC FEVER IN NEW HAVEN. Ed. by John R.

Paul, M.D. Pp. 176. Lancaster, Pa., Science Press Printing Co. 1941. \$1.00.

PROCEEDINGS OF THE CHARAKA CLUB. v. 10. Pp. 260. Baltimore, Williams & Wilkins Company. 1941. \$5.00.

ALLERGY IN CLINICAL PRACTICE. By staff-members of the Cleveland Clinic under the direction of Russell L. Haden, M.D., F.A.C.S. Ed. by J. Warrick Thomas, M.D., F.A.C.P. Pp. 354. Philadelphia, J. B. Lippincott Company. 1941. \$5.00.

ARTHRITIS IN MODERN PRACTICE; the diagnosis and management of rheumatic and allied conditions. By Otto Steinbrocker, B.S., M.D., with chapters on painful feet, posture and exercises, splints and supports, manipulative treatment and operations and surgical procedures. By John G. Kuhns, A.B., M.D., F.A.C.S. Pp. 606. Philadelphia, W. B. Saunders Co. 1941. \$8.00.



## BOOK REVIEWS

**Story of Clinical Pulmonary Tuberculosis.** By Lawrason Brown, M.D. Pp. 411. Baltimore, Williams & Wilkins Co. 1941. \$2.75.

Lawrason Brown, late Director of Trudeau Sanatorium and lecturer in the Trudeau School of Tuberculosis, has written many articles on the subject of tuberculosis, and at the time of his death, December 26, 1937, left numerous notes. It had been his intention to publish these in book form, but owing to his failing health he was unable to accomplish this. After his death his incomplete manuscript was revised and supplemented by friends and collaborators, though many of the chapters were allowed to stand as written. It is a great narrative by one of America's foremost phthisiologists and reflects in many instances the admirable personality and facile style of the man.

The author discusses four periods of medical progress. The first carries us back to the Stone Age. There were centuries of stagnation, but little can be added to the description of the tuberculous patient so accurately portrayed by Aretaeus in the first century or the Greek idea of pathogenesis at the time of Hippocrates (460-370 B.C.) The second period roughly covers the latter half of the seventeenth and all of the eighteenth century, and may be said to extend from the anatomic studies of Sylvius (1650) to the time of the clinical studies of Laennec (1819). The third period covers the first three-quarters of the nineteenth century; from Laennec's classical treatise on auscultation to Villemin's proof of the inoculability (infectiousness) of tuberculosis. The fourth period extends to the discovery of the tubercle bacillus by Robert Koch, an interval of less than twenty years.

From here the story assumes a rapid pace and the rate of progress is startling. Finally we have the perfection of surgical means (artificial pneumothorax and collapse therapy) that support a hygienic-dietetic regime.

Homer L. Sampson of Trudeau Sanatorium, co-author with Lawrason Brown in various publications, has written the chapter on Diagnosis by X-rays. From the epochal discovery by Roentgen to precision methods of the present era, the story is well told.

Edward Archibald of McGill University contributes a chapter on the development of surgical methods. An account of the fundamentals of thoracic surgery and of the part played by the originators is a valuable feature.

Worthy of especial note are the chapters on artificial pneumothorax and the story of the stethoscope. The bibliography, though incomplete, lists selected papers and books. An extensive index is useful for quick reference. The book deserves the attention of the entire medical and allied professions; and those particularly concerned with the problems of tuberculosis will be intrigued by these interesting events, so vividly portrayed.

IRVING S. APPLEBAUM, M.D.

**Synopsis of the Preparation and Aftercare of Surgical Patients.** By Hugh C. Ilgenfritz, A.B., M.D., and Rawley M. Penick, Jr., Ph.B., M.D., F.A.C.S., with a foreword by Urban Maes, M.D., D.Sc., F.A.C.S. Pp. 532. St. Louis, C. V. Mosby Company. 1941. \$5.00.

This synopsis is well conceived and written. It contains a surprising amount of information on the most recent methods and techniques, as well as some very helpful, practical suggestions for numerous procedures. Such practical information is often lacking in most books.

The sections on shock, acid base balance, and fluid balance are brief and suffer therefrom. Other sections, such as those on the gall-bladder, thyroid, and large bowel, are well done.

The confusion which arises from many methods without evaluation does not develop in this book. Its directness and simplicity will be helpful to everyone who does surgery, as well as to the medical student and intern.

C. ABBOTT BELING, M.D.

**Diseases of the Nails.** By V. Pardo-Castello, M.D. 2d ed. Pp. 193 with 98 illus. Springfield, Illinois, Charles C. Thomas, Publisher. 1941. \$3.50.

This excellent monograph is compact, well written and useful both to the general practitioner and to the specialist. The numerous black and white illustrations help greatly in following the text.

After the preliminary chapters on the anatomy and pathology of the nails there are separate chapters on the diseases peculiar to the nails, one on nail dystrophies, one on conditions associated with systemic dermatoses, as well as congenital and occupational nail affections.

One feels indebted to Dr. Pardo-Castello for bringing out this useful monograph in the English language, and we hope to see additional monographs covering other dermatologic subjects.

N. B. HELLER, M.D.

**A Manual of Bandaging, Splinting and Strapping**

By Augustus Thorndike, Jr., M.D., F.A.C.S. Pp. 144, with 117 engravings. Phila., Lea & Febiger. 1941. \$1.50.

This manual is written primarily for inexperienced medical students, pupil nurses, and orderlies and demonstrates the proper technique of dressing, bandaging and splinting.

The illustrative material which Dr. Thorndike has used to present his ideas makes them very simply and easily understood. Emphasis is placed on the principles of support, elevation, immobilization and gentle compression. Precautionary measures to be taken in the application of splints and bandaging, however, have not been mentioned and these are very important items. This practical manual should also be of great aid to nonprofessional groups now taking training in the care of the civilian population in the event of a major military catastrophe.

R. BARNES, R.N.

**1941 Year Book of Public Health.** Ed. by J. C. Geiger, M.D., Dr. P.H. Pp. 544. Chicago, Year Book Publishers, Inc. 1941. \$3.00.

The 1941 Year Book of Public Health meets the standard of thoroughness and conciseness which it set as a standard last year in its first appearance. Particularly interesting are the comments made by the editor on almost all the important contributions. To the busy health officer and the physician who is developing an increasing interest in matters formerly considered the concern of the health department only, this book is invaluable.

JULIUS LEVY, M.D.

**Operative Surgery,** including anesthesia, pre- and post-operative treatment; principles of surgical technic; blood transfusion and abdominal surgery. Ed. by Frederic W. Bancroft, A.B., M.D., F.A.C.S. Pp. 1102. New York, Appleton-Century. 1941. \$10.00.

The editor of this work is to be complimented, first, upon the arrangement of the topics, and second, for the array of eminent surgeons who take part in the several sections.

Many books on abdominal surgery present numerous operations with little critical evaluation of end results. It is refreshing, therefore, to find that the authors have presented their subjects from the standpoint of experience and not for the purpose of making a book full of beautiful pictures. The section on the treatment of intussusception is a good example.

Everyone who does any surgery at all and certainly every intern and resident should regard the chapter on surgical techniques as required reading. It could be profitably read once a month or oftener until its precepts have been carried out by the fingers. The gentle handling and regard for the integrity of tissues during operation are too often taken for granted and never practiced. The section on transfusion is excellent and contains much information regarding reactions, including those due to the Rh factor.

The entire work is beautifully done and should be in the library of everyone interested in surgery.

C. ABBOTT BELING, M.D.

**Textbook of Medicine,** by various authors. Ed. by J. J. Conybeare, M.C.; D. M. Oxon, F.R.C.P. 5th ed. Pp. 1131. Baltimore, Wm. Wood. 1940. \$7.50.

The fifth edition of this well-known textbook of medicine by English authors has been revised to include recent advances in hypertension, sulfonamid therapy, the infectious diseases and other topics.

It is a well-written, concise, practical treatise of bedside medicine. Discussion of controversial matters and experimental procedures have been omitted. Emphasis is placed directly on the problems confronting the general practitioner in his daily rounds.

The material is subdivided to cover the entire field of general medicine and includes brief sections on pediatrics, dermatology, and neuropsychiatry.

It is recommended as a practical presentation of bedside medicine.

H. B. SILBERNER, M.D.

**X-ray Therapy of Chronic Arthritis** (including the x-ray diagnosis of the disease). Preliminary report based on 100 patients treated at Quincy, Illinois. By Karl Goldhamer, M.D., with a foreword by Harold Swanberg, B.S., M.D. Twenty-four original illustrations by the author, two roentgenograms, and four tables. Quincy, Ill., Radiologic Review Pub. Co. 1941. \$2.00.

This small book is divided into two parts, the first devoted to diagnosis and classification of the types of arthritis. The author has used drawings to illustrate his text rather than reproductions of roentgenograms. According to the preface, this was done to illustrate better the most striking and essential features of arthritis. There is some question if this is entirely satisfactory unless a reproduction of the roentgenogram is also used.

The second part deals with the history of x-ray therapy of chronic arthritis, the mode of action of the roentgen rays, the selection of cases to be treated, the technique of treatment, case histories, results and conclusions. Although the report is based on only 100 cases, the author states in the preface that many hundreds of patients with the disease were treated in his private institute in Vienna.

The period of observation for a disease of this type is rather short but this method of treatment deserves further study and it is well to bring it to the attention of the medical profession. It is perhaps unfortunate that the book is not indexed and the contents were not published in one of the national medical journals where it would have been brought to the attention of a greater number of physicians. It should not be considered as a complete dissertation on the subject but rather as a preliminary report.

W. JAMES MARQUIS, M.D.

**About Ourselves.** By James G. Needham. Jacques Cattell Press, Lancaster, Penna., 1941. Pp. 276.

A simply told story of man in his biologic setting, "*About Ourselves*" is an effort to interpret the social and spiritual facets of human nature as they seem to a biologist. The evolution of the body and of the central nervous system is described in bold, easily read strokes. The components of social behavior are broken down into their basic building blocks, and then reassembled so that the reader may see what goes into the complexities of human nature. It is timely to note that Professor Needham interprets war as rooted in "untamed animal instincts", just as the economist explains it in terms of a search for markets, the psychologist as a drive to glory and self-importance, the demographer as the quest of an over-populated country for lebensraum. This inevitable particularism gives the book a quality of unreality, for while it is interesting to see the biologic river flow under all social behavior, it is hardly helpful to forget the soil above it. Not that Professor Needham can be



charged with promising too much, for he offers his volume as "an exposition of human nature without any plans for improvement". For the intelligent layman, the book is challenging and thought-provoking; it interests rather than inspires. And if it will not fire the imagination, it provides at least some food for quiet reflection.

M. W. BERGMAN, M.D.

**American Illustrated Medical Dictionary**, a complete dictionary of the terms used in medicine, surgery, dentistry, pharmacy, chemistry, nursing, veterinary science, biology, medical biography, etc., with the Pronunciation, Derivation, and Definition. By W. A. Newman Dorland, A.M., M.D., F.A.C.S. 19th ed., with the collaboration of E. C. L. Miller, M.D. Pp. 1647. Philadelphia, W. B. Saunders Co. 1941. \$7.50.

This dictionary should prove an important advance in the quick and accurate reference to, and differentiation of, medical terminology, together with its related subjects.

Having recourse, as we do, in medico-legal work to the latest findings of the medical profession, where passing in constant review are the opinions of eminent medical authorities pro and con as to trauma, chemical or mechanical irritation, etc., and their resultant effects on the human body, this dictionary is of invaluable assistance, listing not only the latest tests, methods of treatment and terminology, but all the new drugs, together with their derivatives, source and properties.

In simplifying the subjects by using the principal nouns and including all qualifying nouns under the main definition, the new dictionary has succeeded in reducing the time ordinarily necessary for reference.

Frequent cross-reference and lucid explanations in differentiating between similar sounding medical terms will go far toward eliminating the usual conflicts that the lay and semi-expert mind suffer in trying to ascertain subtle shades of difference that might appear obvious to the medical man.

To the physician, student, medical secretaries, and medico-legal layman, this work should prove of utmost importance.

F. W. O'BRIEN, B.A.

**Accidental Injuries**; the medico-legal aspects of workmen's compensation and public liability. By Henry H. Kessler, M.D., Ph.D., F.A.C.S. 2d ed. Pp. 803. Philadelphia, Lea & Febiger. 1941. \$10.00.

The first edition of this book was so well received and so useful that the author\* revised the volume and has given a further record of his vast experiences and observations. A comprehensive study of the numerous injuries to which the workingman is subjected is presented in an orderly manner. The anatomic changes caused by the injuries are clearly set forth with prognosis and probable type and amount of the permanent loss of function. These estimates should be of great help to claim agents in adjusting the compensation of the employed. The section on accident-neurosis is of special interest as it gives a clear insight into this problem. After reading the chapter on occupational diseases, it is apparent that slow but persistent progress is being made in protecting the employee from many hazards.

This book is recommended to industrial physicians, claim agents, insurance companies, clinics and hospitals, and to any physician interested in industrial medicine.

CHARLES G. CRANE, M.D.

**Sulfanilamid and Related Compounds in General Practice**. By Wesley W. Spink, M.D. Pp. 256. Chicago, Year Book Publishers, Inc. 1941. \$3.00.

This small monograph on the sulfonamids is well presented and comprehensive. It does not pretend to be an exhaustive summary of this field and consequently lacks some of the advantages of a book of that type. On the other hand, it does represent the experience of a single group with the sulfonamid drugs and as such merits close attention. It should prove useful as a guide for the general practitioner and medical student.

The developments in research for the sulfonamids are constantly in progress in many centers so that no book can hope to be entirely up to the minute on the date that it is published, even though the manuscript contains all that was new when it was written.

C. ABBOTT BELING, M.D.

## DIABETES AMONG JEWS

The Fourteenth Anniversary of the *Hebrew Medical Journal* is commemorated by a special issue on "Diabetes Among Jews". The contributors to the symposium include Drs. Joslin, Morrison, Allen and Rongy.

Diabetes is found 75 per cent more common among Jews than among non-Jews. In fact, 6 per cent of all middle-aged Jewish women and 4 per cent of middle-aged Jewish men suffer from this disorder. Among married Jewish women the ratio is even higher, reaching the amazing proportion of 12 per cent.

It is estimated that more than 500,000 people in the United States suffer from diabetes today. The authors believe that the inheritance of racial sus-

ceptibility, influenced by intermarriage between diabetics, accounts for the high tendency to this disease, and that the cultural preference for high carbohydrate diets is probably also a factor in the Jewish community. The lack of exercise resulting from the fact that a disproportionate number of Jews are engaged in sedentary occupation is probably also a factor.

A copy of this interesting issue may be secured from the Editorial Office of the *Hebrew Medical Journal* at 983 Park Avenue, New York.

The issue is written in English.

\*A member of The Medical Society of New Jersey.



## ● THE BULLETIN BOARD ●

"The Management of Acute Abdominal Emergencies" will be discussed on Thursday evening, *January 15*, before the Gloucester County Medical Society meeting at the Woodbury Country Club. Dr. William T. Lemmon will be the essayist. A presentation of "The Neuroses from the Standpoint of the General Practitioner" by Dr. J. C. Yaskin has been scheduled for the February meeting.

• • •

The Atlantic County Medical Society will hold its January meeting at the Hotel Traymore on Friday, *January 16, 1942*. Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, will be the guest of honor, and all physicians are invited to come to Atlantic City this week-end and participate in the program.

• • •

Physicians are invited to take part in a joint meeting with the New Jersey Branch of the Pharmaceutical Association on Thursday evening, *January 29*, at the Academy of Medicine in Newark, at 9:00 p.m. The Speaker, Dr. Richard A. Deno, is head of the Department of Biologic Sciences at Rutgers, and he will speak on the Sulfonamid Drugs.

• • •

Dr. Elias J. Marsh, President-Elect of The Medical Society of New Jersey, will speak to the Essex County Medical Society on Thursday evening, *February 12*, at the Academy of Medicine, Newark, on "The Administrative Program of Organized Medicine in This State". Other speakers include: Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society, who will discuss "Current Trends Towards the Organization of Medical Services". Dr. Charles Schlichter, Chairman of the Society's Medical Preparedness Committee, will review "The Role of the Physician in Civilian Defense".

• • •

The American Orthopsychiatric Association will meet at the Hotel Statler in Detroit, *February 19, 20, 21, 1942*, for a conference on study and treatment of behavior and its disorders. Programs may be secured by writing to Dr. Helen P. Langner, Vassar College, Poughkeepsie, N. Y.

The American College of Physicians announces its twenty-sixth Annual Session on *April 20-24, 1942*, at St. Paul, Minnesota. Interested physicians may secure a more complete program from Mr. Edward Loveland, American College of Physicians, 4200 Pine Street, Philadelphia, Pa.

• • •

An annual cash prize of \$100.00 and a gold medal are offered by the Mississippi Valley Medical Society for the best previously unpublished paper on any subject of practical value to the general practitioner. Contestants must be members of the American Medical Association. No contribution shall exceed 5,000 words, and five copies of the manuscript must be submitted prior to *May 1, 1942*. Manuscripts should be sent to, and details may be secured from, Dr. Harold Swanberg, 209 W. C. U. Building, Quincy, Illinois.

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A practical, fact-packed 60-page booklet on Allergy is available for ten cents from the Superintendent of Documents, Government Printing Office, Washington, D. C. This highly useful manual was written by L. H. Cirsp, M.D.

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The January programs of the Academy of Medicine are listed on page 41 of this issue.

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The Wayne County Medical Society announces that its headquarters at 4421 Woodward Avenue, Detroit, have been given to them as a Christmas present by the Whitney Realty Company, which was the owner of the building.

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Each month during the first half of 1942 the Illinois State Department of Health, the Children's Bureau of the United States Department of Labor and the Chicago Lying-in Hospital, will offer a four weeks' graduate course in obstetrics in Chicago. The entire tuition fee is \$15.00. The courses include lectures, demonstrations, clinics and ward rounds. Additional information and application blanks are secured by writing to the Postgraduate Course, Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago.

## PERSONAL NOTES

Dr. Frederick Dilger of Hackensack, a member of the Bergen County Medical Society, has been appointed Medical Director of the Newark office of the New Jersey Rehabilitation Commission. He succeeds Dr. H. H. Kessler, a member of the Essex County Medical Society, who last month resigned as Medical Director of that office to enter active duty in the Medical Corps of the Navy.

Dr. S. C. Yachnin, a member of the Passaic County Medical Society, has enrolled for two more years in the Army Medical Corps. Latest news from Lieutenant Frank DeGrace of Passaic indicates that he is in Hawaii.

Dr. Harold Walker of Wyckoff has been called to active duty in the U. S. Naval Reserve. Lieutenant Commander Walker is stationed in the office of the District Medical Officer's Headquarters of the Third Naval District, New York City.

Dr. Sol Fanburg, a member of the Essex County Medical Society, has been named Consulting Dermatologist to the Orange Memorial Hospital.

Dr. Martin Quirk of Red Bank and Dr. Joseph Raffetto of Asbury Park have been certified by the American Board of Pediatrics.

At its recent meeting in Boston, the American College of Surgeons inducted into Fellowship several members of the Passaic County Medical Society. Among them were Drs. Henry D. Bongiorno, Frank J. Jani and Leslie R. Taber.

Dr. Harry Silver, a member of the Essex County Medical Society, has been made Attending Pediatrician at the Memorial Hospital in Newark.

Dr. Milton Roemer of the Passaic County Medical Society has been appointed to the staff of the New Jersey State Department of Health.

Dr. G. W. Cummins, a member of the Warren County Medical Society, was honored on November 13 at a dinner given in Belvidere in commemoration of his having served his patients and the profession for half a century. Dr. Thomas K. Lewis, President of The Medical Society of New Jersey; Dr. William Costello, Chairman of the Board of Trustees; Dr. Joseph Londrigan, Second Vice-President of the Medical Society, and Dr. L. A. Wilkes, Executive Officer of the Society, were guests at the meeting.

Dr. Harry Bossard, Reporter for the Warren County Medical Society, presented Dr. Cummins with a certificate giving him honorary life membership in that organization. Arrangements were also made by the Warren County Medical Society to provide life membership for Dr. Cummins in the state and national societies.

An especially bound volume of Dr. Cummins' publication on the medical history of Warren County was presented to the Society by Mrs. Cummins, an officer in the Daughters of American Colonists.

Dr. Ralph Buchanan of Phillipsburg, President of the Warren County Medical Society, presided at the dinner.

Dr. I. J. Wolf, whose prize essay on the treatment of rickets by a single massive dose of ertron was published in this *Journal* in September, has received a grant from the National Research Laboratories in Chicago for a further study of therapy in rickets.

Dr. David Eisenberg of the Essex County Medical Society has become a Fellow of the American College of Surgeons.

Dr. Frank Carrigan of the Essex County Medical Society has become a diplomate in radiology.

# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

January, 1942

No. 1

THE diagnosis of clinically significant pulmonary tuberculosis is readily reached by the average practicing physician if certain fundamental procedures are used. One of the functions of the American Trudeau Society, the Medical Section of the National Tuberculosis Association, is to disseminate among the general medical public information about advances in these procedures. The treatment of tuberculosis in general is a specialized procedure which should at least be initiated with the counsel of a specialist. The American Trudeau Society offers a forum where practitioner and specialist can meet to discuss the technical problems involved as well as their practical applications.

### THE AMERICAN TRUDEAU SOCIETY

By HAROLD G. TRIMBLE, M.D., *President*

The American Trudeau Society is a natural outgrowth of the American Sanatorium Association. The Sanatorium Association was formed in the days when most of the medical problems, with reference to tuberculosis, revolved around the various tuberculosis institutions and when many of the men in tuberculosis work came by their interest because of their own personal history as tuberculosis patients. With increasing diagnostic facilities and with advances in various forms of treatment, general medical interest in diseases of the chest, including tuberculosis, was significantly increased and many young physicians became interested in these problems as such.

Theoretically, it seemed profitable, and practically it so developed, that contact between what one may call the "pure" specialist in tuberculosis and the internist, who while having other interests was intimately concerned with diseases of the chest, would benefit both. On this basis, then, with the co-operation of the National Tuberculosis Association, the American Trudeau Society was born—an organization of medical men with a nucleus of those interested primarily in tuberculosis and including, also, a group interested in general internal medicine.

The idea of such a society which would be inclusive rather than exclusive, that is, not confined to men who were primarily specialists in diseases of the chest, caught hold among the medical public, as evidenced by the rapid increase in mem-

bers. Such an organization has a dual responsibility: first, to push forward the already rapidly advancing knowledge with regard to the technical medical as well as public health aspects of tuberculosis; second, to see that the known facts are disseminated even more rapidly among medical men in general. These functions are best achieved through the work of strong active committees with as wide a geographic distribution as possible, and with a diversity of personnel to bring forth all aspects of the problem at hand. There are but few physicians of prominence in the field of tuberculosis or its closely allied specialties, who are not active members of the Trudeau Society. Members give generously of their time, talent, and information to work out such special problems as may be referred to them, or such as they feel worthy of further investigation and study.

To provide information that is interesting, accurate and well thought through, to avoid mere novelties without overlooking new developments of intrinsic merit, and to review new phases of old problems, is no mean task. Such is the work of our Program Committee in arranging the annual meeting. If attendance is an index, their efforts have been crowned with success.

As new technics develop in the field of laboratory medicine in problems allied with diseases of the chest, it is extremely valuable that the procedures be independently evaluated, not by single individuals but by a group of physicians who are



actively working in the same field, and who have the facilities and personnel to try out the particular procedure and evaluate it, without bias or undue enthusiasm. This is a task that our Committee on Standard Laboratory Procedures does and reports from this group are issued as promptly as possible for our information and guidance.

Developments in the fields of diagnosis and treatment are based largely upon technical developments in allied sciences. It is not always that these newer developments get to the medical student rapidly and effectively. Our Committee on Undergraduate Medical Education, consisting of men who are all experienced in teaching and alive to the needs of both student and medical school, is seeking more effective ways to reach this end.

The problem in post-graduate medical education is somewhat different. Practicing physicians are largely creatures of habit. We change but slowly technics we have learned and used so long. Only when we realize that something is really better, a distinct improvement and not merely different, will it be adopted. The purpose of the Committee on Post-graduate Medical Education is to make available as rapidly as possible knowledge of diagnostic technics in the field of pulmonary disease, particularly where it should be used the most, namely, the office of the physician in general practice. The realization today that tuberculosis in its earliest stages, when it is most curable, must be actually sought for, that it ordinarily is without signs or symptoms, is still somewhat of a mental hazard for men who were taught years ago that fever, cough, sputum, etc., are indicative of tuberculosis, and that proper skill with the eyes, fingers and ears is adequate for diagnosis. As many new methods of using the X-ray become simplified, more readily accessible, and less expensive, the known facts regarding their effective use need to be widely disseminated. The Committee on Post-graduate Medical Education is seeking to analyze the results of actual methods that have already been put into practical use and to get such information not to the tuberculosis specialist alone but particularly to the man in general practice.

New methods of X-ray procedure in the diagnosis of pulmonary conditions are in the course of rapid development. Our Committee on X-ray Apparatus and Technique consists of men actively working in the application of X-rays to tuberculosis as a clinical problem as well as those working on technical improvement in existing apparatus. This group is in a position to evaluate the

developments of the X-ray and to give this information to our members and the general medical public.

The tuberculosis sanatorium is, and should be, the focus around which the tuberculosis work of all kinds revolves. As the character of treatment changes, as more technical diagnostic procedures, such as bronchoscopy, develop, and as surgical collapse therapy grows in extent, there must necessarily be some alteration in the physical plant as well as the type of medical care available for the tuberculous patient. Our Committee on Tuberculosis Sanatorium Standards is now in the midst of evaluating these problems and will be able to report what is considered adequate current practice within the near future.

The American Trudeau Society policy, as originally adopted and reaffirmed upon numerous occasions, has been, that one seeking official certification as a specialist in tuberculosis should have a broad background in internal medicine. To that end the Society has a Committee on Co-operation with the American Board of Internal Medicine.

Thousands of professional workers, such as nurses, social workers, health officers, as well as many more members of the general population, have served as board members of tuberculosis associations, on seal sale committees, and in various other capacities. They have a real interest in the developments of technical problems in the field of tuberculosis. To give them authentic advice, advisory committees have been set up for the purpose of reviewing such literature of the National Tuberculosis Association as is already available as well as checking new publications as they are produced. The Committee on Educational Literature and the Committee on Medical Information must necessarily work in very close relation with these large groups of professional and lay persons interested in the general field of tuberculosis. This work to date has been effective, stimulating and productive of much good result.

This, in outline, is the general philosophy and its practical application as applied to the affairs of the American Trudeau Society. Its work covers those phases of the medical aspects of tuberculosis that are mostly problems for the specialists, as well as those that have special appeal to the physician in general practice. Its effectiveness can continue only insofar as both these groups bring to it their current problems, and working through its committees, bring to bear jointly the sound advice and earnest counsel that is only theirs to give.

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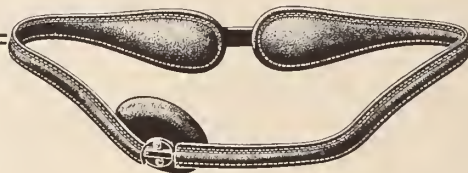
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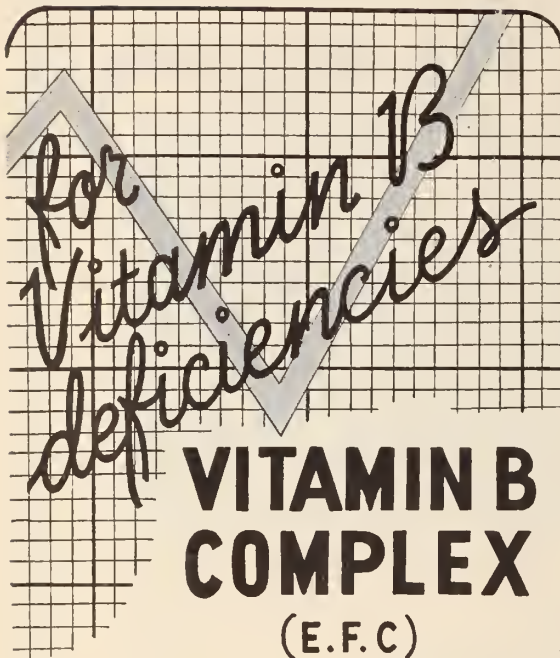
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### CONTENTS—Page 57 to 128

#### EDITORIALS—

A PENALTY—OR A PRIVILEGE?	57
READING THE REJECTION RATE	58
DOCTOR'S DILEMMA	59
PAPER PHOBIA	59
INTELLIGENCE PLUS	60

#### THE WAR—

The Next Step for Physicians	61
Procurement of Medical Personnel (Major Seeley)	62
Procurement of Medical Personnel (Dr. Fishbein)	63
Medical Examiners for Selective Service	64
Equipment for Emergency Medical Units	65
A Military Surgeon's Prayer	66
Purchase of Automobile Tires	67

#### ORIGINAL ARTICLES—

RESPONSIBILITY OF THE MEDICAL PROFESSION TOWARDS THE POLITICAL INSTITUTIONS OF THE NATION—Wells P. Eagleton, M.D., Newark, N. J.	68
BENZEDRINE SULPHATE AND THYROID IN THE TREATMENT OF OBESITY—William Kalb, M.D., Newark, N. J.	74
THE TIMING OF BLOOD COAGULATION—C. H. Knauer, M.D., Trenton, N. J.	75
ROLE OF THE GENERAL PRACTITIONER IN APPENDICITIS—Royal Schaaf, M.D., Newark, N. J.	76
EMOTIONAL FACTORS IN BRONCHIAL ASTHMA—J. A. Haiman, M.D., New York, N. Y.	80
RELATION OF THE GENERAL HOSPITAL TO PSYCHIATRY—J. Berkeley Gordon, M.D., Marlboro, N. J.	84
ECTOPIC AND OTHER ACCIDENTS OF PREGNANCY AS CAUSES OF MATERNAL MORTALITY. Maternal Welfare Article No. 67—Arthur W. Bingham, M.D., East Orange, N. J.	87

#### STATE ACTIVITIES—

Welfare Committee	91
Subcommittee on Medical Practice	99
Subcommittee on Public Health	102
Subcommittee on Legislation	105
Subcommittee on Public Relations	106
Committee on Auxiliary Medical Services	107
Medical Service Administration Moves	107
Annual Committee Reports	108
Questionnaire on Automobile Drivers	108
With New Jersey Medical Authors	109
Heart Committee and the Defense Program	109
Outline of Our Society's History	110
ANNUAL REGISTRATION OF PHYSICIANS—Earl S. Hallinger, M.D., Trenton, N. J.	111
Pneumonia Serum Available	112

#### THE BULLETIN BOARD

113

#### COUNTY SOCIETY REPORTS—

Atlantic, Bergen	114
Burlington, Essex, Gloucester	115
Mercer, Middlesex, Monmouth	116
Morris, Passaic, Salem	118

#### WOMAN'S AUXILIARY—

Coming Events	119
State Meeting	119
"G" Is for Gloucester County	120
State Nursing Association	120
Questionnaire to Members	121
County Auxiliaries	121

#### THE BOOK SHELF

123

#### TUBERCULOSIS ABSTRACTS

127

Roster of Officers, Advertising Page 3a

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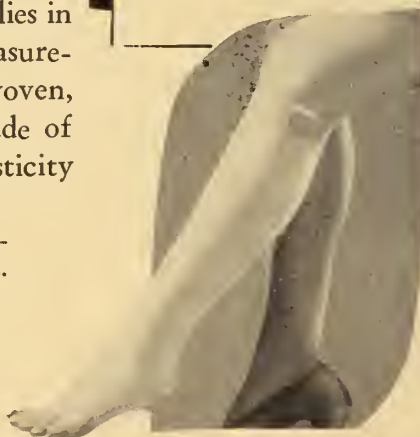
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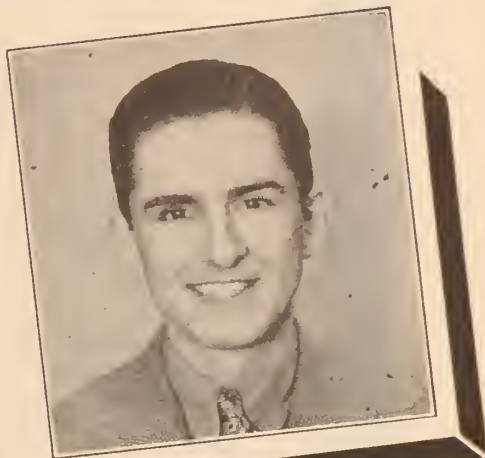
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Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
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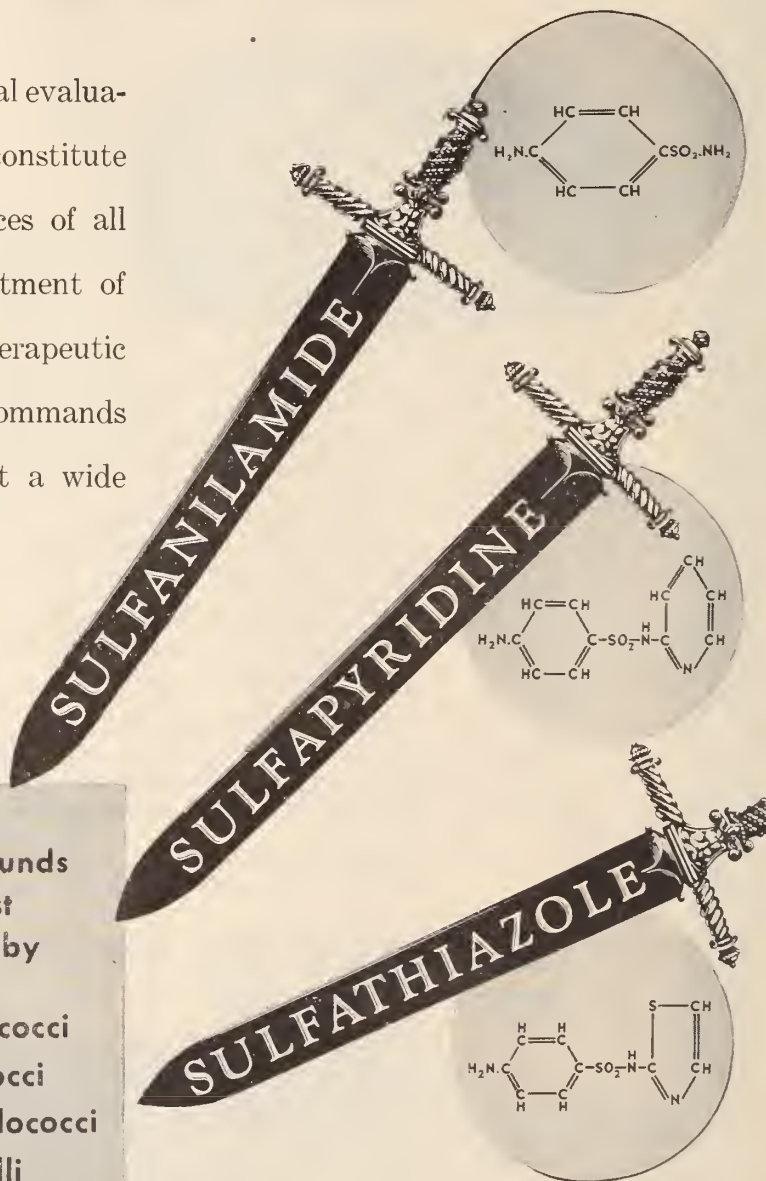
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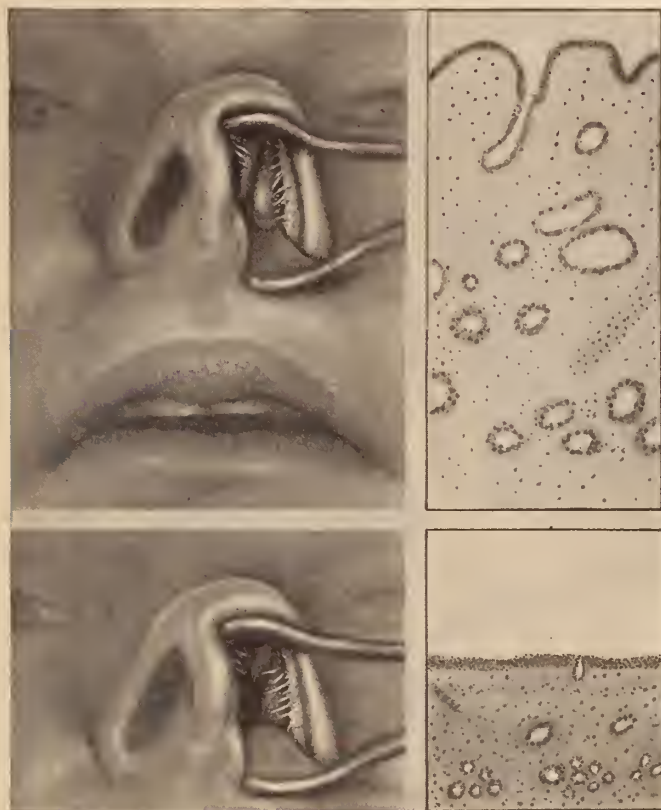
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(Above) Allergic Rhinitis  
(Below) Five Minutes after application of Neo-Synephrin Hydrochloride

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IN ALLERGIC RHINITIS, relief from nasal congestion is the thing the patient urgently demands—the single criterion by which he evaluates treatment.

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## NEO-SYNEPHRIN HYDROCHLORIDE

(laevo-alpha-hydroxy-beta-methyl-amino-3 hydroxy ethylbenzene hydrochloride)

shrinks the nasal mucous membrane swiftly—with more prolonged effect than ephedrine, and with lower toxicity in therapeutic dosage.

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**Jelly**  $\frac{1}{2}\%$  (in collapsible tubes with nasal applicator)



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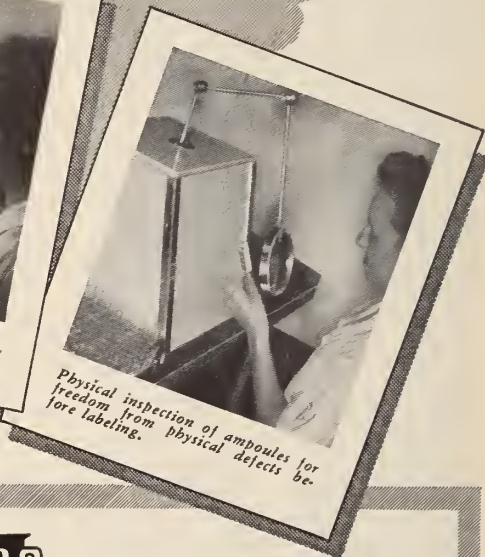
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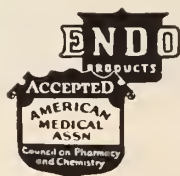


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EPINEPHRINE in OIL, 1:500, ampoules	SOLUTION POSTERIOR PITUITARY, ampoules
EPINEPHRINE HYDROCHLORIDE, 1:1000, ampoules and vials	SULFANILAMIDE, tablets
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the American soldier's identification  
tag now carries his blood type.

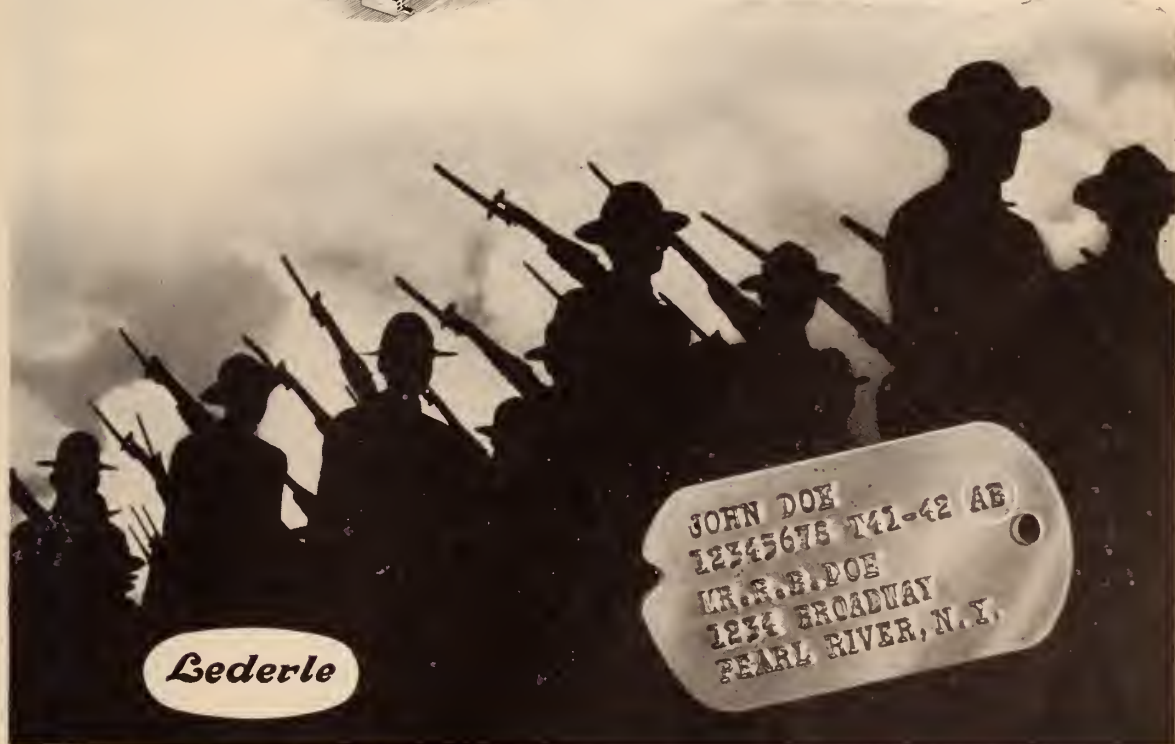
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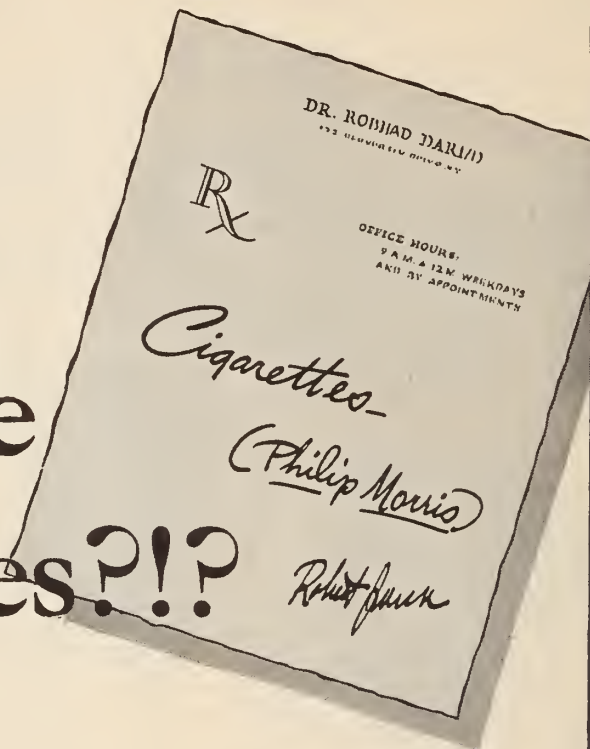


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\*Facts from: Proc. Soc. Exp. Biol. & Med., 1934, 32, 241-245; N. Y. State Jrl. of Med. Vol. 35, No. 11,590; Arch. of Otolaryngology, Mar. 1936, Vol. 23, No. 3,306.

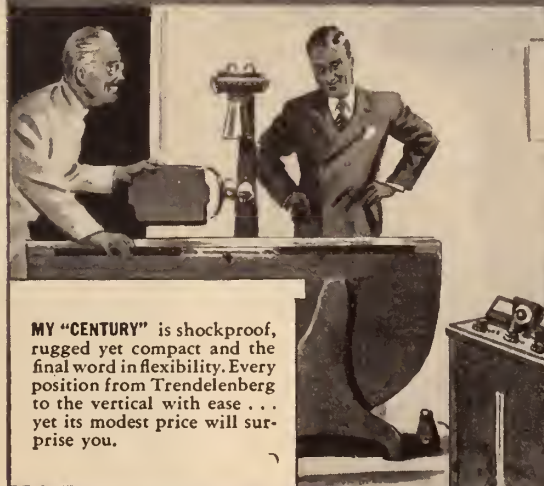
# ONE DOCTOR TELLS ANOTHER



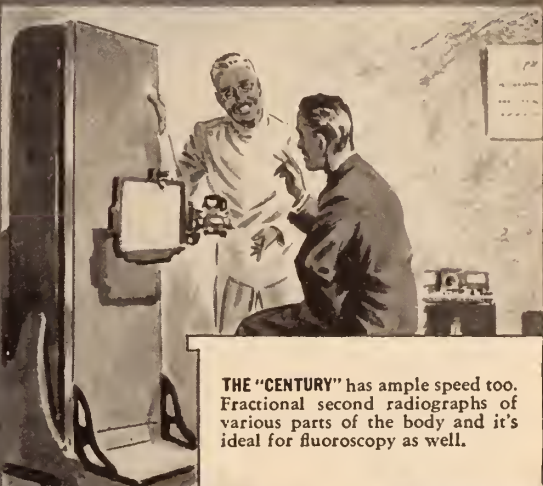
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- (1) 1811. The Art of Preserving All Kinds of Animal and Vegetable Substances for Several Years, M. Appert, Black, Perry and Kingsbury, London.  
1938. Food Research 3, 13.  
1938. Ibid. 3, 91  
1939. Canned Food Reference Manual, American Can Company, New York  
1941. Ind. Eng. Chem. 33, 292



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

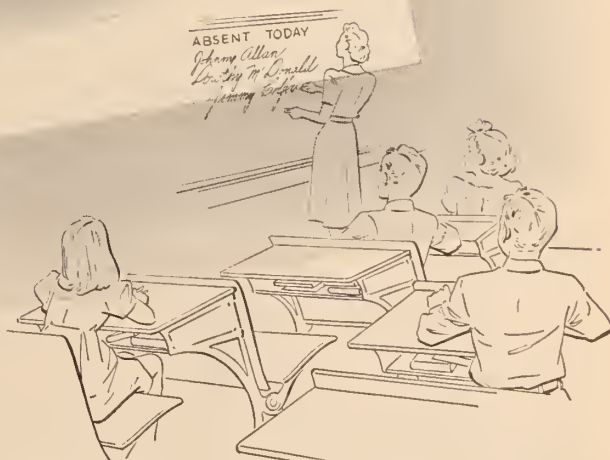


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## A PENALTY—OR A PRIVILEGE?

Some doctors have been reluctant to enroll with the Procurement and Assignment Service. The blank was published in the January issue of this *Journal* and a form will be mailed to each physician later this month. By signing, a doctor indicates that he is available for service to the Government in his own branch of medicine or surgery. It was expected that practically 100 per cent of the physicians would respond to this call. Certainly it is hard to see how anyone can do otherwise.

At least one physician has said, however, that he felt under no obligation to sign the blank because he had received no individual request to do so. Its publication in a journal, he felt, was a hit-and-miss device which could not be meant to have any personal application to him.

Another doctor said: "Why should I stick my neck out?" adding that if and when the Government wanted him it would get him without his inviting himself to be selected.

Perhaps the wierdest objection was this one: "No other profession in the country is expected to offer itself en masse in this way, no other group is being asked to dislocate itself completely; why should doctors be the victims of discrimination?"

Discriminated against? Is the offering of your services to your country a discrimination or a privilege? Is it to medicine's discredit or to medicine's pride that it was the first profession to offer itself? What other group now has the opportunity of securing officer's status in the Army immediately on entering from civilian life? The answer is none. This privilege—that of entering directly into the status of an officer—is given to the medical profession and only to them.

If America loses this war, few of us will be able to practice honest medicine at all; and many will not want to survive the holocaust of a Fascist America. Of all who have a stake in democratic victory, surely the intellectual, the scien-



tist, the professional man has the largest. A physician who has to be coaxed into contributing his services to the winning

of this war must indeed be troubled in conscience, narrow in vision, and mean in spirit.

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### READING THE REJECTION RATE

The high rejection rate among draftees has been much ballyhooed as evidence of the physical unfitness of American youth or as proof of the inadequacy of medical care. We doctors know that this is a spurious interpretation. But does the public know it?

Army "standards" are simply criteria set up for the purposes of selecting satisfactory specimens, on a large scale, for combat service from our male population in the age bracket which represents the acme of physical fitness. From such material our leaders and officers in the armed forces are chosen in our greatly expanded military preparation. These standards may be made less stringent if necessary to obtain the man-power needed to achieve victory.

Many men who cannot meet present meticulous standards of physical fitness for the Army can and do make outstanding contributions, not only in peacetime but in wartime, in fields quite as important as the firing line. We would prefer to see all our citizens perfect, according to military standards, just as we would like to see our factories work at 100 per cent efficiency and economy. This is, and always has been our aim, but we must realize that human beings always fall short of the goal of ideal physical structure and function. Let us emphasize the fact that young men today are unquestionably living in a more sanitary environment, getting better food, and are better housed and clothed than ever before.

While there is considerable room for improvement, the failure to measure up to a "standard" for military fitness simply means that we can be somewhat im-

proved physically through medical or other aid. It has no absolute meaning in terms of the general level of physical health in the country. Any effort to translate the percentage rejected by selective service into a parallel percentage as "physically unfit" is highly misleading.

Many rejections are for "moral" or other nonphysical reasons, though they appear in the statistics as "rejections" and thus load the figures. Rejections for poor vision, which constitute one of the major causes, are a token of our highly verbalized, mechanized culture. No one can say that more persons have refractive errors today than a half century ago, because never before have so many people been subjected to ocular examination or required to make such continual use of the eyes. Insufficient teeth, the number one cause for rejection, speaks for financial inability or personal unwillingness to secure dentures rather than for any defect in dental care itself. The tuberculosis rejection has tailspinned from 10 per cent in 1917 to less than 2 per cent today. The prevalence of middle ear disease is a proof of the soundness of medicine's demand that the "minor" illnesses of childhood should be seen promptly by physicians.

No doctor should permit anyone to use these apparently high rejection rates as a springboard for the criticism of the profession or of the distribution of medical care. Such an evaluation is misleading, inaccurate and defeatistic. Every doctor, every medical society, has a duty to scotch such misinterpretations whenever they appear.

PUBLIC RELATIONS COMMITTEE.

## DOCTOR'S DILEMMA

Is it a doctor's duty to report a physically unfit driver to the Motor Vehicle Department or should he keep this information confidential? Here is a real dilemma for the conscientious physician. Suppose he knows that the patient has epilepsy, coronary disease or some other condition which makes him a potential hazard behind the wheel of his car. To send this information to the Motor Vehicle Commissioner may seem like a gross breach of confidence, as well as an act apparently detrimental to the patient whose interest he is sworn to protect. On the other hand, to suppress this information is to invite a serious accident and perhaps to be party to the snuffing out of many lives.

Fortunately the New Jersey doctor is

not obliged to make a decision at this time, since the Committee on Traffic Accidents wants, at the moment, only a numerical evaluation of the number of persons in the state with disabilities of this sort. There can be no objection to that, and no reason for any doctor's failure to fill out the information blank without giving names of patients. Subsequent policy can be determined only if accurate information as to the size of the problem is available. This information can be secured if the doctors of the state will continue their long-established habit of cheerfully co-operating in any project helpful to public health or public welfare; and in no other way. Please turn to page 108 and fill out the blank promptly.

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## PAPER PHOBIA

Few words in the medical lexicon carry as much contempt as the phrase: "paper-work". Every doctor who serves the government, a social agency, an insurance company, or an industrial plant complains that he is strangled by paper-tape, and protests the need for monotonous entry and re-entry of data on complicated printed forms.

The doctor's ready answer is to abandon the "paper work" to some clerical assistant. This, he feels, frees him for the diagnosis and treatment of illness. But the matter is not so simple. The assignment of such work to medically untrained personnel invites errors, blurs the physician's own grasp of the distribution of his findings, and makes one more inroad in the already too common tendency to divert medical procedures into non-medical hands.

There is something to be said for the bogey of paper-work after all. It is a practice which builds up habits of precision, forces a certain amount of order-

liness into the writer's thinking, and arouses a consciousness of the fact that the individual physician's task is only one part of a greater job. For instance, the physician who carefully fills in all the blanks on a death certificate is compelled to organize his diagnostic terms into some standard nomenclature. When a certificate is returned because "apoplexy" is not an acceptable word, and "thrombosis" or "hemorrhage" or "embolus" is the approved term, the doctor has to pause a moment, weigh the possibilities of embolus, hemorrhage and thrombosis, and determine which most closely conforms to the clinical picture. It is not a bad discipline; certainly it discourages the slovenly thinking which would dismiss the death as "apoplexy".

The mere recording of data on a communicable disease report form symbolizes the fact that this one case is but a single item in the flow of copy to a health department, and is a fragment of the battery of findings on which all our vital sta-

tistics are built. The construction of valid statistical data, in turn, is the basis for life insurance rates, an orientation point for health department activities, a brief for health-minded legislators, and a yardstick for measuring the adequacy of the community's medical care. Our entire structure of vital statistics—and all the services and activities which stem from them—would tumble in a year if individual doctors failed to submit accurate reports of births, deaths and illnesses.

The doctor who serves an Old Age Assistance Board, a City Relief Department or any other government agency is inclined to grumble at the elaborate forms which he has to fill in order to collect his fee. Yet the entire machinery of governmentally-subsidized medical care would stall without the statistical foundation on which the budget allotments are based; and these in turn, are built up by the accumulation of the much abused forms.

The distribution of potent drugs like the opiates, barbiturates and sulfonamids, can be regulated only by limiting their prescription to physicians. But concurrent with the monopoly thus given to the doctor, is a duty to restrict the distribution of these drugs, which is possible only by a kind of professional policing which requires much paper work.

This is not to deny that the geniuses who construct the blanks and questionnaires are often at fault for arranging the forms badly and for demanding unnecessary details. But to respond by ignoring the blanks or by submitting carelessly framed answers is no solution.

In this day of increasing governmental interest in the physician's activities, the doctor who is careful, patient and thorough in the routine task of filling out forms is the one who builds up in the official files, a personal record for reliability, meticulousness and accuracy. The physician who submits forms dotted with illegible scrawls or yawning with wide open spaces, enters himself in the books as hasty, careless or inaccurate: an unjustified conclusion to be sure, but an inevitable one.

Birth certificates, commitment papers, sick lists, quarantine reports, communicable diseases notifications, death certificates, narcotic registration applications, prescription blanks, questionnaires, disability reports, and all the other time-taking ink-absorbing jobs are petty nuisances. But they need not stand in the way of the doctor's personal or professional progress; after all, no practitioner worthy of his license will let himself be stymied by a wall built of nothing more substantial than a wad of paper.

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### INTELLIGENCE PLUS

Physicians are intelligent men and women. But intelligence alone is not enough. It must be supplemented by special training and experience to insure proficiency. Because a person is intelligent he is not necessarily qualified to speak authoritatively on a subject outside his own field of competence.

For example, we observe that physicians, as a rule, are not ipso facto brilliant economists or executives. Ministers of the Gospel hardly qualify in legal

problems, without special training and experience in that field. In this war, the military and naval battles will be won by our trained combat forces. Each of us can best contribute to the war effort within our proper scope of function. We can, in war and peace, with profit all stick to our own special jobs, and leave to others those duties which they can best discharge.

LEROY A. WILKES, M.D.,  
Executive Officer.



# THE WAR

## THE NEXT STEP FOR PHYSICIANS

The following memorandum has been sent from the Assignment and Procurement Service under the title: *Recommendations to Physicians with Reference to the National Emergency*.

The "enrollment" to which the memorandum refers will be effected through special questionnaires to be mailed to all physicians later this month. There will also be published in the Journal of the American Medical Association and in the March issue of this *Journal* a special "physical rating blank" which will enable physicians to evaluate their physical status with reference to requirements for the various branches of the military, civilian and naval services.

All inquiries concerning this service should be directed to: Executive Officer, Procurement and Assignment Service, 5654 Social Security Building, Independence Avenue at Fourth Avenue, S. W., Washington, D. C.

### ALL PHYSICIANS UNDER FORTY-FIVE

All male physicians in this category are liable for military service and those who do not hold commissions are subject to induction under the Selective Service Acts. In order that their service may be utilized in a professional capacity as medical officers, they should be made available for service when needed. Wherever possible, their present positions in civil life should be filled or provisions made for filling their positions, by those who are (a) over 45, (b) physicians under 45 who are physically disqualified for military service, (c) women physicians, and (d) instructors and those engaged in research who do not possess an M. D. degree whose utilization would make available a physician for military service.

Every physician in this age group will be asked to enroll at an early date with the Procurement and Assignment Service. He will be certified for a position commensurate with his professional training and experience as requisitions are placed with the Procurement and Assignment Service by military, governmental, industrial or civil agencies requiring the assistance of those who must be dislocated for the duration of the national emergency.

### ALL PHYSICIANS OVER FORTY-FIVE

All physicians over 45 will be asked to enroll with the Procurement and Assignment Service at an early date. Those who are essential in their present capacities will be retained and those who are available for assignment to military, governmental, industrial or civil agen-

cies may be asked by the Procurement and Assignment Service to serve those agencies.

The maximal age for original appointment in the Army of the United States is 55. The maximal age for original appointment in the Naval Reserve is 50 years of age.

### INTERNES

All internes should apply for a commission as First Lieutenant, Medical Corps, Army of the United States, or as Lieutenant (J. G.), United States Navy or Naval Reserve. Upon completion of 12 months' internship, except in rare instances where the necessity for continuation as a member of the staff or as a resident can be defended by the institution, all who are physically fit may be required to enter military service. Those commissioned may then expect to enter military service as medical officers; those who failed to apply for commission are liable for military service under the Selective Service Acts.

### HOSPITAL STAFF MEMBERS

Internes with more than 12 months of internship, assistant residents, fellows, residents, junior staff members, and staff members under the age of 45, fall within the provisions of the Selective Service Acts which provide that all men between the ages of 20 and 45 are liable for military service. All such men holding Army commissions are subject to call at any time and only *temporary deferment* is possible, upon approval of the application made by the institution to the Adjutant General of the United States Army certifying that the individual is temporarily indispensable. All such men holding Naval Reserve commissions are subject to call at any time at the discretion of the Secretary of the Navy.

All men in this category who do not hold commissions should enroll with the Procurement and Assignment Service. The Procurement and Assignment Service under the Executive Order of the President is charged with the proper distribution of medical personnel for military, governmental, industrial, and civil agencies of the entire country. All those so enrolled whose services have not been established as essential in their present capacities will be certified as available to the Army, Navy, governmental, industrial, or civil agencies requiring their services for the duration of the war.

Note—Attention is also directed to the article "Government Now Procuring Medical Personnel" on page 62 of this *Journal*.

## PROCUREMENT OF MEDICAL PERSONNEL

"When the bombs fell on Pearl Harbor, the medical profession was not caught short!" So said Major Sam Seeley in a talk to the New Jersey Hospital Association at New Brunswick, January 15, 1942. Major Seeley, Medical Corps, United States Army, is Executive Officer of the Procurement and Assignment Service.<sup>1</sup> To this service falls the duty of finding qualified physicians for vacancies in the Army, Navy, Public Health Service, Veterans' Administration, United States Civil Service and all other government agencies, industrial, military and civilian. His aim, he explained, is "to fit the round pegs in the round holes". It is hoped to assign each doctor to the work for which he is best qualified. This is possible because of the registration of physicians conducted at the request of the Surgeon-General by the American Medical Association in the summer of 1940, because of the coöperation of state medical societies in that program, because of the help offered by specialized medical societies, and because of the internal machinery of the Procurement and Assignment Service itself. Major Seeley's talk answered a number of queries commonly raised by doctors. Following is a list of hypothetical questions to which Major Seeley's address provided the answer:

*Will the Government bring pressure on physicians engaged in essential civilian tasks, to enter the armed forces?*

There will be no raiding of civilian institutions and agencies. It is hoped that wherever a physician under the age of 45 is essential to a hospital, medical school, health department, medical society or industry, he will seek to train an older (or physically ineligible) physician for that task so that the former may be released for more active duty. An absolutely essential practitioner of any age, however, will be permitted to remain in civilian life if his indispensability is clear.

*Who will determine indispensability?*

Special boards of physicians have been set up in each Corps Area; to them special state boards will be responsible. The actual investigation of the doctor's status will be conducted by local boards composed of practitioners who know the community's needs. These local representatives will not make the decision; they will merely report the facts in a consultative capacity.

*How are a specialist's qualifications determined?*

For some time now, many agencies have been

coöperating on this. These include the specialty medical societies, the examining boards, the offices of the National Resources Planning Board, and other agencies having special facilities for this work. On the basis of these studies, each specialist is rated, and a confidential report of his standing is submitted to the Procurement and Assignment Service.

*What are the "classes" of specialists?*

Specialists are grouped in four grades. In class 1 are men who are definitely "outstanding" specialists of national standing. In class 2 are men who can take care of all branches of their specialty without supervision and with full responsibility. Class 3 includes competent assistants, capable of assuming responsibility when necessary, while in class 4 are placed men still training in a specialty, or those men engaged in specialized practice who are not yet ready to assume class 3 responsibilities.

*May a man secure his specialty rating by writing for this information?*

No, the classifications are confidential.

*How many physicians does the Army need?*

On November 1, 1940, the War Department needed 1400 physicians to complete its tables of organization. The Army has, of course, expanded since then, and consequently more physicians are needed. For reasons of military policy, the exact figures are not being made public.

*Are physicians needed in all ranks?*

Most of the vacancies are in the rank of first lieutenant and captain.

*May a civilian receive a senior rank when entering service?*

The Secretary of War is authorized to issue new commissions in any rank up to that of Colonel. This will be done as the needs of the Army demand, the rank assigned depending on the age, qualifications, hospital status, skills and experience of the applicant. It is considered appropriate, however, to protect the seniority of medical officers in the Reserve Corps, National Guard and Regular Army, who have earned promotion, but who have not yet been promoted because of lack of vacancies in the higher grades. In general, first choice will be given to these men when vacancies develop, other things being equal.

*Is the Medical Reserve Corps now receiving applications for new commissions?*

No, the Reserve Corps is closed; but physicians may apply for commissions in the Army of the United States. Such commissions are for the duration of the war plus six months unless vacated sooner by the War Department.

1. See page 5 and page 18 of the January 1942 Journal.



*May physicians under the age of 45 be drafted as private soldiers?*

Nothing in the Selective Service Act forbids this, though it will be the policy of selective service to defer physicians applying for commissions until they can receive such commissions and enter the Army of the United States with officer status. Any physician placed in class 1A by his local draft board, who is faced with the possibility of early induction as a private soldier, may appeal this classification and could, if necessary, carry his appeal to the State Director and ultimately the National Director of Selective Service.

*How many physicians in the country are now under the age of 45?*

About 60,000 of the country's 185,000 doctors are under the age of 45.

*What is the status of medical students?*

A. All students holding letters of acceptance from the Dean for admission to medical colleges and freshmen and sophomores of good academic standing in medical colleges should present letters to their local boards. This is necessary to be considered for deferment in Class II-A as a medical student. If local boards classify such students in Class I-A, they should immediately notify their deans and if necessary exercise their right of appeal to the Board of Appeals. If, after exhausting such rights of appeal, further consideration is necessary, request for further appeal may be made to the State Director and if necessary to the National Director of the Selective Service System. These officers have the power to take appeals to the President.

B. Junior and senior students, physically disqualified for commissions, are to be recommended for deferment to local boards by their

deans. These students should enroll with the Procurement and Assignment Service for other assignment.

C. All junior and senior students in good standing in medical schools should apply immediately for commission in the Army or the Navy. This commission is in the grade of Second Lieutenant, Medical Administrative Corps of the Army of the United States, or Ensign H. V. (P) of the United States Navy Reserve, choice as to Army or Navy being voluntary. Applications for commission in the Army should be made to the Corps Area Surgeon of the Corps Area in which the applicant resides and applications for commission in the Navy should be made to the Commandant of the Naval District in which the applicant resides. Medical R. O. T. C. students should continue as before with a view of obtaining commissions as First Lieutenants, Medical Corps, upon graduation. Students who hold commissions, while the commissions are in force, come under the jurisdiction of the Army and Navy authorities and are not subject to induction under the Selective Service Act. The Army and Navy authorities will defer calling these officers to active duty until they have completed their medical education and at least 12 months of internship.

*Should a physician with an obviously disqualifying physical defect fill out the enrollment blank<sup>2</sup> for the Procurement and Assignment Service?*

Yes. A doctor may have a defect which disqualifies him from Army or Navy Service, yet he may be valuable in a Veterans' Hospital, in a Civilian Defense position, at a public health post, etc. Every physician responsive to his country's call should fill in the enrollment blank when it is mailed to him.

#### DR. FISHBEIN'S ADDRESS

To study the indispensability of certain physicians to civilian and industrial activities, a special board has been set up in each Corps Area. So explained DR. MORRIS FISHBEIN (Editor of the Journal of the American Medical Association) in an address to the Atlantic County Medical Society, January 16, 1942. For the Second Corps Area (New York and New Jersey) this board consists of Dr. A. W. Booth and Dr. Samuel Kopetzky of New York, and DR. WILLIAM J. CARRINGTON of Atlantic City

(a Fellow of The Medical Society of New Jersey). In each state, a physician has been designated to clear the data to the Corps Area boards. For New Jersey, the Board's representative is DR. CHARLES SCHLICHTER of Elizabeth.

"The medical profession has been preparing for this war since 1938," said Dr. Fishbein. He estimated that 28,000 physicians are working without compensation on local and appellate draft boards. In seeking to evaluate the medical man-power of the country, a calculation was made showing that there were some

2. This blank will be mailed to every physician within a month.



120,000 physicians in the country under the age of 55, and about 60,000 under the present draft ceiling of 45. Dr. Fishbein doubted if more than half of these would be available, because of physical disability or civilian indispensability. In the latter category were doctors essential to medical schools, hospitals, health departments and industry. The tally made it likely that only about 30,000 physicians would be available under present standards, and the army now needs, or soon will need, about 27,000 physicians. It thus appears that practically every medical practitioner under the age of 55—certainly every one under the age of 45—who was not disabled or indispensable—would be called into service in one way or another. Under the circumstances, it would appear wise for physicians in this age group to offer themselves promptly by enrolling with the Procurement Division.<sup>2</sup> Dependency will not be considered an appropriate basis for exemption from service.

Dr. Fishbein reviewed the status of medical students (see answers to questions, page 63). He reminded the audience of the pressures being brought by grade B medical schools and cultists to have their graduates and practitioners commissioned in the medical corps, and lauded the Surgeons-General of the Navy and Army for their refusal to lower the educational standards. Any such recognition of cultists, he warned, would inevitably cheapen and impair

standards of civilian medical practice for years to come.

The rôle of the American Medical Association in the formulation and operation of the Procurement Service was explained and the coöperation of state and county medical societies in this task was cited. The methods of evaluating the qualifications of specialists were reviewed (see answers to questions, page 62).

The rapid expansion of industry will call for many physicians and surgeons in this field. While about 10,000 doctors now have some contact with industrial medicine and surgery, it was estimated that scarcely more than 1200 of these were competent, bona fide, experts in this specialty. Steps are now being taken to train more men for this work.

Dr. Fishbein warned that government control of medical practice might persist after the war, but felt that if the profession itself continued as it had begun, to administer and police the service of providing for the medical needs of the armed and civil services, the chance of this sequel was much reduced. "On the medical profession itself," Dr. Fishbein concluded, "has been placed the responsibility of meeting all the medical requirements of the armed services. The thousands of enrolment blanks that poured into Washington during the first few weeks of the year are evidence of the initial success of that effort."

## MEDICAL EXAMINERS FOR SELECTIVE SERVICE

### A MEMORANDUM FROM STATE HEADQUARTERS

1. It has come to the attention of this headquarters that some examining physicians feel their services are not being sufficiently utilized under the present local board examination plan.

2. It is unfortunate that the projected rehabilitation plan for remediable defects found in registrants could not have been instituted concomitantly with the new examination plan on January 1. These two phases of Selective Service work—physical examination and rehabilitation—are complementary, and as soon as plans are completed for rehabilitation, the need for further medical assistance will be manifest.

3. The new plan is nation-wide in scope, and, while the former plan worked perfectly in New Jersey because of the whole-hearted coöperation of the medical and dental profes-

sions, it is not necessarily to be assumed that this was true in all states.

4. As large numbers of doctors enter the military service, the load on those remaining in civilian practice will grow tremendously, and part of the thought behind the new procedure is to lighten their burden to the end that the needs of the civilian population will continue to be met.

5. It is the observation of this headquarters that most of the local board physicians welcomed the change on January 1 and are being kept quite as busy as formerly because of the increase in the number of men examined. Although the work of the medical advisory boards is presently negligible under the revised procedure, it is expected that those boards will be greatly needed later when the rehabilitation work begins.

E. N. BLOOMER,  
Acting State Director,  
Selective Service System.

2. This blank will be mailed to every physician within a month.

## EQUIPMENT FOR EMERGENCY MEDICAL FIELD UNITS

The Office of Civilian Defense has released a bulletin on the equipment and operation of Emergency Medical Field Units. The list of equipment which follows represents the minimum material required for emergency care at the disaster site. It is suggested that this be carried in two portable boxes, each 15 by 20 by 8 inches, and the equipment be so organized that each physician on the squad will have a separate container of working supplies for himself. List 1 below gives the working supplies for one physician's team for a first aid post.

## List No. 1—Equipment for a First Aid Post

## INSTRUMENTS

Scissors, surgical, Mayo 5½" curved	1
Scissors, surgical, Mayo 5½" straight	1
Scissors, bandage, angular, 7½"	2
Forceps, hemostatic, Rochester, curved, 6¼"	6
Forceps, hemostatic, Rochester, straight, 5½"	6
Forceps, tissue, spring 5½"	1
Forceps, tissue, spring, mouse-tooth, 5½"	1
Forceps, tongue holding 7"	1
Tube, breathing (airway) hard rubber or metal (adult)	1
Tube, breathing (airway) hard rubber or metal (child)	1
Retractor, tissue, double end nested 9" and 10" Army type, pair	1
Syringe, hypodermic, Luer, 2 cc.	2
Needles, hypodermic, 25 gage, ½"	12
Needles, hypodermic, 19 gage, 1½"	6
Tubes, constriction (length 3") for needles	12
Stoppers, tube, constriction for needles	12
Handles, Bard Parker, No. 3	2
Blades, Bard Parker, No. 10, package of 6	1

## SUTURE MATERIAL

Catgut, plain No. 1, tubes, boilable	6
Silk, dermal, medium, 40" strand, package of	6
Needles, suture, catgut, size 1, half-circle, trochar point, Mayo	6
Needles, cutting edge, straight	6

## DRUGS

Morphine sulfate syrettes, 0.015 gm.	20
Morphine sulfate syrettes, 0.030 gm.	10
Sulfathiazole, powder, vials, 5 gm.	12
Ointment, ophthalmic, boric acid, 5%, tube, 4 gm.	1
Jelly, tannic acid, tube, 45 gm	2
Alcohol, denatured, ethyl, bottle, 500 cc.	1
Ammonia, aromatic spirit, bottle, 60 cc.	1
Sodium bicarbonate	½ lb.
Phenobarbital tablets, 0.30 gm	100
Caffeine sodium benzoate, ampules, 0.5 gm	12
Epinephrin hydrochloride, 1:1000	20 cc.

## DRESSINGS AND BANDAGES

Compress, gauze, 4" x 4"	100
Compress, gauze, 2" x 2"	200

Pad, surgical, 8" x 10" (Dakin)	25
Bandage, gauze, 2"	24
Bandage, muslin, 4"	24
Bandage, triangular, muslin, 50" x 36" x 36"	24
Cotton, absorbent, roll, sterile	2 oz.
Cotton batting, roll	1 lb.
Plaster, adhesive, 2" x 10 yards, roll	2

## MISCELLANEOUS SUPPLIES

Pins, safety, large	48
Splints, basswood	12
Depressors, tongue, wood	24
Applicators, wood	25
Sheeting, rubber (45" x 72")	1
Basins, white enamel, 9" x 6" x 1⅞" (one with cover)	2
Stove, gasoline (Coleman)	1
Pencil, indelible	1
Pencil, dermatographic (red)	1
Pads, heating, chemical	4
Pads, heating, refills, chemical	4
Gloves, surgeon's, rubber, size No. 8 (latex), pair	2
Flashlight (two-cell)	1
Battery, dry cell, for flashlight, No. 950	4
Lantern, electric, dry-cell type	1
Battery, dry cell, for lantern, No. 6	4
Cups, paper	25
Brush, nail	1
Soap, hand, bar	2
Towels, hand	12
Matches, safety, box	3
Tourniquet, field, web	3
Bag, laundry, small	1
Tags, identification, book of 20	6
Casualty record book	1

List 2 indicates the equipment for a casualty station and contains the bulky articles which would impair the mobility of a first aid post. It is expected that these larger pieces of equipment would be issued from the casualty station to the first aid post as the need arises. Biologic products, including plasma, antitoxin, etc., should be obtained as needed from the parent hospital.

## List No. 2—Equipment for a Casualty Station

Trunk, Army type	1
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## TRACTION SPLINTS

Splint, arm, hinge, Thomas	4
Splint, leg, half-ring, Army type	4
Splint, Thomas, leg, child	2
Splint, arm, Murray Jones, child	2

## SUTURE MATERIAL

Catgut, plain No. 1, tubes, boilable	12
Silk, dermal, medium 40" strand, package of 12	1
Needles, suture, size No. 1 half-circle, trochar point, Mayo	12
Needles, cutting edge, straight	12

## DRUGS

Morphine sulphate syrettes, 0.015 gm.....	40
Morphine sulphate syrettes, 0.030 gm.....	20
Sulfathiazole, powder, vials, 5 gm.....	24
Ointment, boric acid, ophthalmic, 5%, tube, 4 gm.....	2
Jelly, tannic acid, tube, 45 gm.....	4
Alcohol, denatured, ethyl, 70% .....	1 qt.
Ammonia aromatic spirit, bottle 60 cc.....	1
Sodium bicarbonate .....	1 lb.
Phenobarbital tablets, 0.03 gm.....	200
Caffeine sodium benzoate ampoules, 0.5 gm.....	24
Procaine hydrochloride tablets, 0.18 gm.....	100
Sodium chloride compressed tablets, 1 gm.....	100

## DRESSINGS AND BANDAGES

Compress, gauze, 4" x 4" .....	200
Compress, gauze, 2" x 2" .....	400
Pad, surgical, 8" x 10" (Dakin) .....	50
Bandage, gauze, 2" .....	48
Bandage, muslin, 4" .....	48
Bandage, triangular, muslin (50" x 36" x 36")..	48
Cotton, absorbent, roll .....	1 lb.
Cotton batting, roll .....	2 lb.
Plaster, adhesive, 2" x 10 yards .....	4

## MISCELLANEOUS SUPPLIES

Pins, safety, large .....	100
Splints, basswood .....	30
Depressors, tongue, wood .....	100
Applicators, wood .....	50
Sheeting, rubber (45" x 72") .....	2
Basins, white enamel, 9" x 6" x 1 7/8" (2 with cover) .....	4
Stove, gasoline (Coleman) .....	2
Catheter, urethral, rubber, F14 .....	4
Pencil, indelible .....	4
Pencil, dermatographic (red) .....	4
Pads, heating, chemical .....	8
Refills, pads, heating, chemical .....	8
Gloves, surgeon's, rubber, size 8 (latex), pair...	4
Lantern, electric, dry cell .....	2
Batteries, dry cell, lantern, No. 6 .....	12
Cups, paper .....	50
Nail brush .....	2
Towels, hand .....	24
Matches, safety, package of 12 boxes .....	1
Tourniquet, field web .....	6
Bag, laundry, small .....	2
Tags, identification book (books of 20) .....	6
Razor, safety .....	1
Blades, safety razor .....	12

## A MILITARY SURGEON'S PRAYER

God of Battle, grant that the wounded may swiftly arrive at their hospital haven, so that the safeguards of modern surgery may surround them, to the end that their pain is assuaged and their broken bodies are mended.

Grant me as a surgeon, gentle skill and intelligent foresight to bar the path to such sordid enemies as shock, hemorrhage and infection.

Give me plentifully the blood of their non-combatant fellow man, so that their vital fluid may be replaced and thus make all the donor people realize that they, too, have given their life's blood in a noble cause.

Give me the instruments of my calling so that my work may be swift and accurate; but provide me with resourceful ingenuity so that I may do without bounteous supplies.

Strengthen my hand, endow me with valiant energy to go on through day and night; and keep my heart and brain attuned to duty and great opportunity.

Let me never forget that a life or a limb is in my keeping and do not let my judgment falter.

Enable me to give renewed courage and hope to the living and comfort the dying.

Let me never forget that in the battles to be won, I, too, must play my part, to the glory of a great calling and as a follower of the Great Physician. Amen.

JOHN J. MOORHEAD, M.D.,  
in a communication to the New York Sun.



## MEMORANDUM FROM PROCUREMENT SERVICE

The Procurement and Assignment Service has just notified the Medical Preparedness Committee that a rapid expansion of the Medical Corps of the Army is expected, and that within ten days some men should receive notices that they are desired. The list of men who have already volunteered is being checked with the New Jersey Procurement Chairman, and the men thus found available will be notified personally.

In general, it is considered appropriate for every doctor under 36 to volunteer for active

service if he is now or can soon be made available. Many specialists up to 45 years of age will also be needed at once.

The Corps Area Chairmen met in Washington on Friday, January 30, to discuss the details of the organization. A special pamphlet of information on procurement and assignment may be secured by addressing Major Sam F. Seeley, Executive Officer, Procurement and Assignment Service, New Social Security Building, "C" Street at 4th Street (S.W.), Washington, D. C.

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## THE DOCTOR'S AUTOMOBILE

A survey by the Michigan Motor Vehicle Department, reprinted in the *New Jersey Autoist*, shows that physicians make more "necessary" automobile trips than any other car owner. In general, it is estimated that only 74 per cent of trips are "necessary", while the M.D.'s figure is 88 per cent. Further, the phy-

sician gets more mileage out of his car than anyone else, the average being 13,200 miles a year per doctor. And doctors drive the newest cars, too. Only half of one per cent of all physicians have cars more than 8 years old. Some 71 per cent have automobiles less than 2 years old.

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## PURCHASE OF AUTOMOBILE TIRES

The procurement of new automobile tires depends upon eligibility and need. Eligibility is based upon the type of vehicle rather than the eligibility of a person. Eligible Vehicles, Section 404 of the Regulations, lists vehicles operated by a physician, surgeon, visiting nurse or veterinary, used principally for professional services and any vehicle used principally as an ambulance.

To obtain a tire, a physician must make a

request from his local rationing officer. This officer will usually be found in the office of the local Civilian Defense Council. He must fill in the prescribed form, demonstrate the need for a new tire or tube which is to be "installed at once on a wheel or rim to replace a tire or tube no longer serviceable". He must turn in his old tire or tube to the dealer, and at no time will be allowed more than five serviceable tires per vehicle.

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## BLOOD TESTS ON REGISTRANTS

Selective Service and State Department of Health will, on February 14, 15 and 16, arrange mass blood tests during the third registration in those areas where statistics have shown a relatively high incidence of syphilis.

All physicians in those areas will be asked to volunteer their services for certain hours on registration days to assist with this pre-habilitation program.

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## BOMBS AND NEUROSES

Life in a bomb shelter seems better mental hygiene than isolated struggle against bombing disaster. Dr. R. D. Gillespie, in giving the Salmon Memorial Lectures, reports that shelter life with its common sharing of danger, has

helped people better withstand bombing perils than isolation in small groups. Isolation in small groups contributes to the development of neurosis: the feeling of being with others, even in an insecure shelter, brings courage.

## RESPONSIBILITY OF THE MEDICAL PROFESSION TOWARDS THE POLITICAL INSTITUTIONS OF THE NATION

By WELLS P. EAGLETON, M.D., Newark, N. J.

Address delivered at formal opening of the "Eagleton Civic Medical House" of the Academy of Medicine of Northern New Jersey, in Newark, October 16, 1941.

Tonight I shall attempt to tell you why Mrs. Eagleton and I not only take pleasure in the presentation of this House to the Academy of Medicine of Northern New Jersey, but have regarded it as our duty to the city in which we live, and to the profession among whom we have worked. For both have treated us handsomely.

Mrs. Eagleton and I think of nothing else, talk of nothing else, read of nothing else except the War. And our whole desire in the years that may be left to us to work, is to do our bit toward stopping Hitler—"that embodiment of hate and terror"—to help drive his Nazi gangsters back into their Prussian lair, where the German people can make as much of a God of Hitler as they please.

And fervently do we desire to be of help in uprooting Hitlerism in America, which can best be done by making democracy work more effectively than in the past; this by every high-minded man and woman doing his or her share in the operation and guidance of our government.

Here in New Jersey, we believe that a definite service to our government can be accomplished if physicians are encouraged to assume their proper share of responsibility; actively aiding our local, state and federal authorities in solving any political, economic and social problem having a medical aspect. We, the medical profession, should take the lead and direct the medical phases of these problems.

For the weakness of democracy in our country during the past half century has been the attitude of educated intelligent men toward political life—their neglect to foster and develop the spiritual and ethical principles on which our government was founded. Furthermore, the great improvement in the technical operation of our industries and the great material prosperity of our people have been accompanied by degeneration in political life. Educated men have turned away from the affairs of the people, from government—turned away from the duty of participating in it. For it is *our* government; it is as pure and idealistic, or as corrupt and materialistic as it is made by representatives elected by *us*.

### WHAT IS DEMOCRACY?

We live in a democracy. Our government is not a complete democracy but it is the best experiment towards democracy that the world has ever seen, despite the sneers of the Fascist-minded.

Democracy is the rule of the majority; but the intelligence and spiritual content of the majority are mediocre. Consequently it has been said—and with some truth—that a democracy is the rule of the mediocre. But members of the medical profession are educated men and are possessed of an idealism and of an intellectual integrity far too rare in our day. Perhaps the physician has these intellectual and spiritual qualities because of his training and association. And idealism and intellectual integrity are more needed in the political thought of today than ever before.

### EARLY MEDICAL AND POLITICAL HISTORY OF NEWARK

The Puritan settlers—the "Proprietors"—of "Neworke," brought with them their physician, trained in England, who, as was the common practice in all the early English settlements along the Atlantic seaboard, was also their pastor.<sup>1</sup> For it is recorded (by Clark<sup>2</sup>): "The earliest doctors were also pastors."

In Newark (or "Pasayake Towne," as they first called it) they established a theocracy, a combination of Church and State, modelled upon the Puritan Commonwealth type of government,<sup>3</sup> in which the doctor, being an educated and religious man, played a prominent part.

All public questions were decided by discussion in open town meeting. Ralph Waldo

1. He was the Reverend Abraham Pierson, M.D., who in 1665 left England for Connecticut and in 1667 came to New Jersey. Clark says: "Like many other clergymen of his day, he added the practice of medicine to his other duties." As a matter of fact, Newark was named in honor of Dr. Pierson, for he had been ordained at Newark, England. See: CLARK, J. HENRY: *The Medical Men of New Jersey in the Essex District*. Newark, N. J., 1867.

2. CLARK, J. HENRY: *The Medical Men of New Jersey in the Essex District*. Newark, N. J., 1867.

Dr. Clark was President and Historian of the Essex District Society. On page 6 of this book he writes: "During the earlier period in Essex County, we find clergymen performing the double duty of caring for the physical as well as the spiritual interests of their flocks."

3. Records of the Town of Newark. New Jersey Historical Society. 1864. Page viii.

Emerson said: "In this open democracy (of the town meeting) every opinion had utterance; every objection, every fact carried its own weight."<sup>4</sup>

How completely religion was a part of government is shown by the fact that only a member of the "First Church," now the "Old First (Presbyterian) Church," was entitled to vote.

It was from these local town meetings that representative government originated in the English Colonies of Massachusetts Bay (1620), in Connecticut Colony (1639), in Nova Caesarea,<sup>5</sup> or New Jersey (1664). For the Old English Puritan believed that every white man was made in the image of God and consequently was entitled to his say in his own government; and that is the essence of democracy.

Although religious intolerance continued in New England, here in New Jersey the English settlers—Anglican churchmen, Scotch Presbyterians, members of the Dutch Reformed Church, and Quakers—obtained from the Royal Governor, Philip Carteret, in Elizabeth, "a charter," which, in order to insure religious as well as political freedom, stated: "No person shall at any time, in any way, be called in question or in the least punished or hurt, for opinions in religion."<sup>6</sup>

New Jersey, Rhode Island and Pennsylvania were the three Colonies which early declared for religious freedom as later expressed in our Bill of Rights. For the United States' Bill of Rights did not originate in America. Its early history began in England one hundred years previously. With its "religious freedom, free speech, free press, and the right of peaceful assembly," our way of life—the Anglo-Saxon American life—is founded on democratic institutions established in this country by our English forebears, in whose blood flowed a respect for human dignity—which, they believed, was God's gift to them—with a passion for liberty developed by a thousand years of struggle against the entrenched privilege of noble and

of clergy, and against the dictates of foreign priests.

In all the Anglo-Saxon communities the combination of doctor-pastor and doctor-statesman was usual until long after the Revolution; many members of the native clergy being trained for both professions.

For our early English tradition required a physician, a clergyman or a statesman to be educated, to be religious and to have an honorable reputation in the community—in other words, to be a gentleman.

REV.-DR. DICKINSON, A.M. (1688-1747), the first president of the College of New Jersey (later Princeton), was a practicing physician in Elizabeth and also pastor of the First Presbyterian Church of that city from 1708-1747.

The first president of the Medical Society of New Jersey<sup>7</sup> was DR. (and REV.) ROBERT MCKEAN, M.A. (1732-1767), who was the clergyman-physician sent from England to the settlement at Perth Amboy. On Dr. McKean's tombstone we read: "Practitioner of Physic, et cetera, and Missionary from the Society for the Propagation of the Gospel in Foreign Parts, to the City of Perth Amboy."<sup>8,9</sup>

#### PHYSICIAN SIGNERS OF THE DECLARATION OF INDEPENDENCE

It is a matter of pride to all physicians that six of the signers of the Declaration of Independence were doctors<sup>10</sup> (Benjamin Rush, George Taylor, Josiah Bartlett, Matthew Thornton, Lyman Hall, and Oliver Wolcott).

#### EARLY PHYSICIANS AS STATESMEN

During the formative period of our Republic, many of the most important political positions were held by doctors of Northern New Jersey (Burnet, Johnson, and Condit).

DR. WILLIAM BURNET (1730-1791) was a member of the Continental Congress, 1776-1777, and of the United States Congress in 1780-1791. In the Revolution, he was Surgeon-General of the Eastern District until the restoration of peace in 1783. After-

4. EMERSON, RALPH WALDO: *Historical Discourse at Concord*, about 1840. Also, item on "Democracy," *Century Dictionary*, Vol. 2, p. 1526.

5. Nova Caesarea, as the Province of New Jersey was first called, was named in honor of its first governor, Philip Carteret, who had defended the Isle of Jersey in 1649.

6. Chapter 16 of the Charter, "The Concessions and Agreements of the Lords Proprietors of the Province of New Caesarea or New Jersey to and with all and every of the Adventurers and all such as shall settle or plant there," 1681, stated: "That no men, nor number of men upon earth, hath power or authority to rule over men's consciences in religious matters, therefore it is \* \* \* ordained, that no person \* \* \* whatsoever within the said Province at any time \* \* \* hereafter, shall be any ways upon any pretense whatsoever, called in question or in the least punished or hurt, \* \* \* for the sake of his opinion, judgment, faith, or worship towards God in matters of religion. But that all and every such person \* \* \* may \* \* \* at all times, freely and fully have and enjoy his and their judgments, and the exercises of their consciences in matters of religious worship throughout all the said Province."

New Jersey, A History, The American Historical Society, 1930, Vol. 1 (Political and Constitutional by Hugh McD. Clokie, M.A.), pp. 64, 103.

7. EAGLETON, W. P.: Dr. Robert McKean Memorial; Address of Dedication at the presentation of a tablet by the Medical Society of New Jersey to St. Peter's Church, Perth Amboy, New Jersey, Nov. 4, 1923.

Memorial to the late David Combs English, M.D., Address of Dedication, at the Unveiling of the Tablet in His Memory Placed by the Medical Society of New Jersey in the Presbyterian Church at New Brunswick, N. J., on May 15, 1927.

8. EAGLETON, W. P.: Salutation, 1939—"Thou Shalt Not Remove \* \* \* Landmark(s) Which They of Old Time Have Set in Thine Inheritance," p. 5.

9. WICKES, STEPHEN: *History of Medicine in New Jersey, and of Its Medical Men*, Newark, N. J., Martin Dennis & Co., 1879.

10. For synopsis of biographies of the six physician signers of the Declaration of Independence, see:

EAGLETON, W. P.: *A Doctor's Confession of Faith—I Speak of the Children of Hippocrates, of the Cult of Aesculapius*. Address at 33rd Annual Banquet of Washington Medical and Surgical Society, Mayflower Hotel, Washington, D. C., May 5, 1930, pp. 14-16.

Salutation, 1939—"The Physician Signers of the Declaration of Independence, pp. 8-10.



wards he was Presiding Judge of the Court of Common Pleas. He became president of The Medical Society of New Jersey in 1767 and again in 1786.

DR. UZAL JOHNSON (1751-1827) was appointed to the "Provisional Congress" in 1775 but refused the appointment and entered the British Service, as Surgeon of the First Battalion, New Jersey Volunteers (Loyalist).

DR. JOHN CONDIT (1755-1834). His tombstone, in the old parish burying place in Orange, records: "Patriot, Soldier, and Surgeon during the struggle of his Country for Freedom." In the Revolution he participated in the battles of White Plains and Long Island (Battle Hill). Later he became a member of the New Jersey Legislature; and of Congress, both as Representative and Senator. In the United States Senate in 1812, he voted for war.

#### FIGHTING "REBEL-PARSON" PHYSICIANS

The "fighting Rebel-Parsons" of Essex County are famous in American History<sup>11</sup> (McWHORTER of Newark, CALDWELL of Springfield); but it is not generally known that two of the "rebel-parsons" were also "Parson-Physicians" (GREEN of Hanover, and DARBY of Parsippany).

DR. GREEN was a practicing physician all his life. He engaged in many other pursuits. In his autobiography he wrote: "When I entered upon worldly schemes I found them a plague, a vexation and a snare. If I somewhat increased my worldly estate, I also increased my sorrow \* \* \* in all things except the practice of the sick." He was a member of the Provincial Congress and Chairman of the Committee which drafted the first constitution of the State.

DR. JOHN DARBY (1725-1805) "studied theology and afterwards studied medicine". During the Revolution, he followed the twofold avocation. "On Sunday, he supplied the pulpit; and during the week he practiced medicine (Clark<sup>2</sup>). Dartmouth College conferred the honorary degree of Doctor of Medicine on him in 1782 (Wickes<sup>3</sup>).

#### DETERIORATING INFLUENCE OF THE INDUSTRIAL REVOLUTION

Later, government lost its religious and cultural aspect largely due to (a) the philosophy of "to the victor belongs the spoils" of Jackson's administration (1830); (b) the advent of the Industrial Revolution (1850), and the resultant concentration in our cities of large numbers of uneducated immigrants who, after five years' residence, were admitted in overpowering numbers to our electorate; and due to (c) the violence and lawlessness that accompanied the exploitation of our West after the Civil War.

At the same time the physician passed out

of political life because rapid progress in medical science demanded his whole attention. Politics also lost its religious aspect, until today to be called "a politician" is a term of reproach, for it means too often a political grafter, not a gentleman and a statesman. And our people have come to accept the view that "politics has nothing to do with religion" and "should be no concern of the educated, honorable practitioner"; when in reality political life and activity are the machinery through which democratic government must function.

In this profound spiritual crisis of today, "in the face of this newest and greatest challenge" (F. D. Roosevelt), when those spiritual realities—truth, love, justice—that we value most highly are openly assailed, insincerity in political thought is evident. The appeasers, the defeatists, the isolationists all talk about "our interests." As if the ideal for which our forebears worked and sacrificed were not of much greater import than "our interests"! For, while it has long been recognized that "the demagogue has been the great strangler of civilization," only since the coming of Hitlerism has it become evident that a man is not a demagogue simply because he stands up and shouts to the crowd.

In a democracy, the real demogogy of the demagogue is in his mind and is rooted in his irresponsibility toward the ideas that he handles—ideas not of his own creation, but ideas which he has taken over from their creators. Demogogy is a form of intellectual degeneration.

#### THOUGHT OF THE SIMPLE PEOPLE IN ENGLAND

In all this confusion, sophistry, evasion and demogogy in political life, what are the simple liberty-loving Christian people, who are so heroically facing Nazi hate and terror, thinking?

I want to read extracts from letters that have come to Mrs. Eagleton and myself from one of our own kin in London—a simple woman, a trained nurse, the widow of a doctor, and so imbued with that indefinable something—that sense of responsibility to the patient, to oneself, and to God that must come to all true doctors and nurses because a human life is so often in their hands.

Her physician husband died among us. She went home to England for a visit, was caught in the War and because of it, stayed there. She writes:

"Never in the history of the world have any people been forced to live through what the peoples of Europe are living through at this time." (Note—not the people of England but of Europe.) "I feel

11. EAGLETON, W. P.: Salutation, 1939. "Thou Shalt Not Remove \* \* \* Landmark(s) Which They of Old Have Set in Thine Inheritance."

proud to be contributing my small share. Most of my spare time is given up to canteen work and during Wednesday's Blitz, several of my colleagues were killed. It was too dangerous for them to go home after the last shift at 10:30 p.m." (she works all day for a living) "and so they spent the night at the canteen. A bomb came and that was the end."

Again: "I am fired with the desire to be of some real practical help in trying to build a new world, which desire, I am convinced, must be imbedded into the younger members of the various communities. The future is in their hands, and unless there is an entire change in our present social order, they will be faced at some later date with what we are passing through now. It must never be, it is all so useless and futile; governing conditions everywhere should be such that it cannot happen again.

And again: "I long so much to see you again, and yet I know that, had I stayed with you, I should have felt I was shirking my duty not to have been here, doing the little I can at this time. The arch-devils were over London last night and gave us an awful time. It was too ghastly. I, with many others, have been spared, and so we carry on."

Carry on! carry on! For what? Carry on to make a better world for those who are to follow. I hear no word of "our interests".

Another story, the authenticity of which I do not vouch for, but which tells why Hitler's gangsters can never conquer the spirit of those in whom the blood of freedom really flows—A man and his wife, 75 years of age, had a small shop in London. One night a blitz-raid demolished it. The next morning he and his wife went to see what could be salvaged. There was nothing. He turned to her and said: "Old woman, I guess there is nothing left for us but to turn on the gas." But the woman, with that fire which, in any spiritual crisis, has always made "the female of the species more deadly than the male," drew herself up and flashed, "What? and let Hitler win? No, sirree!"

#### PHYSICIANS' ALOOFNESS IN THE NATIONAL THOUGHT OF TODAY

And the doctors? What have we been doing to strengthen democratic thought? What part are we playing in public affairs? What sacrifices are we making for the betterment of our political institutions that this land become a better place for all men, high and low, to live in? What sacrifices are we making, as did our early Doctor-Politician-Statesmen and our early fighting Doctor-Parsons?

Individually we are practicing scientific medicine, making our daily calls; serving, *when invited*, on a hospital or health board committee. But, and this is more important, we have failed to assume responsibility for public poli-

cies that are fundamentally medical; we have failed to discuss systematic plans in our county and state medical society meetings for the care of the indigent sick; although we do all the work for them without any compensation in our hospitals, both semi-private and charitable.

And what has our national medical organization been doing? Since we have the largest medical organization in the world—the American Medical Association—composed of 125,000 American doctors, it should be the leader in all policies pertaining to the health of our people. And I am of the opinion that under its leadership machinery should be devised to make the benefits of scientific advances in medicine available to all those whose financial circumstances do not permit of adequate medical services, as well as to the well-to-do.

Instead what has happened? After being adjudged guilty of "violation of the law in restraint of trade" in a Federal Court, the American Medical Association announces: "We are not a political body. We have nothing to do with politics," and this without the assent of the House of Delegates of the A. M. A. Think of the effect of such a do-nothing policy on the American reading public after the A. M. A.'s court record!

Why this evasion of our manifest responsibility? Because (a) the attention of the medical profession as a whole has been directed to the scientific aspects of disease and to the application of this knowledge to the particular patients whom we are treating. For the county and state medical societies are organized almost entirely for scientific purposes.<sup>12</sup> And because (b) participation in political thought by any doctor has been discouraged, and his activities have actually been suppressed by the press of Organized Medicine. If he dares to question that the medical care of the indigent can be improved, he is silenced by the statement that—"American medicine is the best in the world," "or "a doctor should have nothing to do with politics." They confused politics with partizan-ship.

#### EFFECTS OF THIS POLICY

The result of this abandonment of public affairs by educated men—including physicians—is illustrated by what happened in Austria. I witnessed it myself.

In the summer of 1934, I was having luncheon with one of the best known otologists in Vienna. "What," I asked, "is the significance of the big crowd in Frantzens-Platz on Sunday

12. EAGLETON, W. P., Chairman, Welfare Committee, Medical Society of New Jersey: *What the Medical Profession Is Striving For in Politics. Psychology in Medical Practice and Legislation. The Profession's Duty to Itself and to the Nation.* J. A. M. A., 82:2100. (June 28) 1924.



morning, all screaming for "*Anschluss* (Union with Germany)?" He replied: "That crowd gathers every Sunday \* \* \* nobody pays any attention to them. They are paid a schilling or two by the politicians to make a noise. The Austrian Nazis want the offices that the Socialists now hold in the government. But here in the *Allgemeinen Krankenhaus* it has nothing to do with us doctors. The physician's job is to promote scientific medicine, for which Vienna is famed. That is why you came to Vienna." "But," I asked, "isn't Austria a republic now?" "Yes," he answered, "but we doctors have nothing to do with politics. We are not in politics."

Two years later Hitler came. The doctor with whom I talked is now dead, and most of his Jewish associates who are still alive, are refugees in this country. The Nazi gangsters were interested in political domination.

Austria fell to Hitler without a blow, partly because they—the educated, intelligent patriotic citizens (including all of the doctors)—while living in a democracy where public policies are decided by elected representatives, considered politics (the machinery through which democratic government operates) of no concern to them. They wanted to give their whole attention to scientific medicine.

What is the effect of this divorce of organized medicine from political activity here, in our country? Laymen too frequently shape health policies.

We must recognize the fact that not only have we doctors collectively very little political influence, but that today we are actually distrusted by the public. This is because Organized Medicine has failed in political-medical leadership.

Thank God, the Medical Society of New Jersey still leads in all political-medical matters (both in thought and in activity) in our State. Only this year it was publicly thanked for its services to the State in a joint resolution<sup>13</sup> by the New Jersey Assembly and Senate.

#### CONCURRENT RESOLUTION

Adopted by the House of Assembly May 19, 1941.

Concurred in by the Senate May 19, 1941

WHEREAS, The Medical Society of New Jersey, the oldest medical society in the United States, having been founded ten years before the independence of our country, is celebrating in annual convention at Atlantic City, May 20th to the 22nd, the 175th anniversary of its organization; and

WHEREAS, The Medical Society of New Jersey and its members have rendered over this long period

of years signal service to the public welfare of this State; therefore

*Be It Resolved*, That the House of Assembly of the New Jersey State Legislature (the Senate concurring) extends to the Medical Society of New Jersey its congratulations upon its 175th anniversary and its best wishes for the continued success and service of this organization; and

*Be It Further Resolved*, That a copy of this resolution, signed by the President of the Senate and the Speaker of the House, and attested by the Secretary of the Senate and the Clerk of the House, respectively, be forwarded to Doctor Watson B. Morris, President of the Medical Society of New Jersey, at Haddon Hall, Atlantic City, New Jersey.

The public have gradually come to believe that many medical men are incompetent because of constant reiteration of disparaging statements by certain members of the profession. But take it from me, who know you all, you are good enough doctors.<sup>14</sup> But physicians—each and all of us—need to be better American citizens; we have a duty to become physician-statesmen.

And what is being a good American? My concept is, that a good American is one who has faith in democratic representative government, who aids in the evolution and development of its institutions, and who is willing to fight for their preservation.<sup>15</sup> President Roosevelt voiced the sentiment of every real American when he said:<sup>16</sup> "We are willing to fight for the simple faith in the democracies of the world!"

#### THE WILL TO ACCOMPLISH ADMINISTRATIVE TASKS

The very history of this Academy shows what doctors can do once they start. Do you realize that this Academy is one of the few large institutions in Newark that has not a cent of debt? That its property can be liquidated today for more than was originally expended on its construction, every dollar of which has been repaid? If I were to tell you how little it has cost to put the Eagleton Civic Medical House into working order, you would hardly believe me. Why the low cost? Because Dr. Joseph Clarken wanted to do the job for his fellows and you. He gave up a whole summer to it. Because our President, Dr. Edward Sprague, took pride in it.

14. EAGLETON, W. P.: *Idealism in Medicine*. Address in response to the toast "Medicine" at Twenty-fifth Anniversary of the Practitioners' Club of Newark, May 6, 1913. Published in the *Journal of The Medical Society of New Jersey*, 1913.

15. EAGLETON, W. P.: *Americanism; An Appeal to the Medical Profession to Enter Public Life*. Address at the "Victory Dinner," 31st annual banquet of the Practitioners' Club of Newark, N. J., May 5, 1919; *J. Med. Soc. New Jersey*, 1919.

16. ROOSEVELT, FRANKLIN D.: Speech of May 4, 1941.

13. See *Journal of The Medical Society of New Jersey*, June, 1941, page 328.



This spirit of comradeship, this desire to contribute to the common good, animated Mrs. Eagleton and myself in giving you this House and the adjoining grounds.

We believe that we can enlist a larger body of men to become better American citizens by furnishing adequate accommodations and facilities for the discussion of civic problems that have a medical phase.

Our purpose is to provide a place where young doctors especially will be encouraged to gather to express their views, and to discuss any subject that has a medical aspect—be it social, economic or political. Here they shall have a place to meet their fellow-doctors, be they conservative, liberal or radical.

#### DEDICATION TO LEADERSHIP

This House symbolizes our conviction that doctors, as a class, are high-minded patriots. We know that in them is a deeply imbedded idealism that makes them respond to every noble thought, to every upward reach. So this property is given to you doctors in the faith that you will make this gift serve its purpose, helping you to take a growing interest in political life, as well as in your profession, and to become better citizens; so that you will be leaders in political-medical thought and in political-medical action.

May it help to make each and all of us realize our responsibilities to our government and to our political institutions when we say, "I am an American Doctor!"

15 Lombardy Street

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## STUTTERING

"In a sense, stuttering develops after it is diagnosed, not before," Wendell Johnson, Ph.D., says in *Hygeia*.

"Also, the diagnosis of stuttering is practically never made, in the first instance, by a speech expert. Practically all of America's one million stutterers were originally diagnosed by their parents, teachers or other untrained observers. By far the majority of these diagnoses, when first made, were probably wrong."

Speech pathologists are leaning toward the conclusion that stuttering is a form of learned behavior; it seems increasingly doubtful that it is due to organic abnormality.

"In the usual case," Dr. Johnson declares, "when a mother says for the first time that her three-year-old boy is stuttering, she is not really making a statement about the child's speech. \* \* \* She is merely indicating the standard of speech fluency that she would expect of a three-year-old boy and she is probably paying no attention to the circumstances under which the boy is attempting to speak. \* \* \* The speech of children, under free play conditions in nursery school, is such that on the average one out of every four words figures

in some kind of repetition. A great deal of repetition is perfectly normal.

"Of most parents of stuttering children it can probably be said that if they had a good knowledge of the circumstances under which speech tends to be fluent, they would most probably have never regarded their children as stutterers, or as defective or abnormal."

The author contends that as soon as a child realizes that his parents consider him a stutterer, he learns unconsciously to hold his breath, to press too hard with his lips and to push too hard with his tongue against his upper teeth. Since actual effort and strain make for failure in speech, a deepening sense of inferiority and discouragement ensues.

Dr. Johnson distinguishes between stuttering in children and that in adults. "They stutter differently. They feel differently about it. They must be handled differently. A careful consideration of these differences leads to a theory of stuttering that is in some respects new, and that is definitely encouraging. It does not tend to make the stutterer as defective or abnormal as older theories have made him appear.

# AMPHETAMINE (BENZEDRINE) SULPHATE AND THYROID EXTRACT IN THE TREATMENT OF OBESITY: OBSERVATIONS ON 500 CASES

By S. WILLIAM KALB, M.D., Newark, N. J.

From the Nutrition Clinic, Department of Medicine, New York Post Graduate Medical School and Hospital,  
Columbia University.

It has recently been suggested that amphetamine (benzedrine) sulphate is more dependable than thyroid extract in the treatment of obesity because it produced anorexia,<sup>1</sup> delayed the emptying time of the stomach<sup>2</sup> and increased the basal metabolic rate.<sup>3,4,5</sup> However, Rosenthal and Solomon<sup>6</sup> have found little evidence to substantiate these claims. Because of these conflicting findings, the present study was undertaken.

## PROCEDURE

Five hundred patients who were 10 to 125 per cent overweight were placed on low-caloric high-protein diets ranging from 800 to 1500 calories daily. The diet selected for each remained unchanged throughout the period of study. The patients were weighed weekly for at least 16 weeks. During this period of observation, the patients received in addition to the sub-maintenance diet at intervals of four weeks (a) amphetamine (benzedrine) sulphate, (b) thyroid extract, (c) amphetamine (benzedrine) sulphate and thyroid extract or (d) a placebo.\* The dose of amphetamine (benzedrine) sulphate was 20 mg. and of thyroid (Parke-Davis)—180 mg. However, the order in which these substances were prescribed varied for selected groups of patients. In all, ten such groups were studied.\*

## RESULTS

The table demonstrates that weight loss was greatest during the first four weeks of treatment regardless of the kind of medication employed. Mean weight loss per week for each

EFFECT OF AMPHETAMINE (BENZEDRINE) SULPHATE, THYROID EXTRACT AND COMBINATIONS OF THESE ON  
WEIGHT LOSS OF 500 OBESE INDIVIDUALS ON SUB-MAINTENANCE DIETS

(Figures in "Weight-Loss" column represent average number of pounds lost per week.)

Group	No. of Patients	1-4 Weeks		5-8 Weeks		9-12 Weeks		12-16 Weeks	
		Medication	Weight Loss	Medication	Weight Loss	Medication	Weight Loss	Medication	Weight Loss
A	88	Benzedrine	2.6	Benzedrine & Thyroid	2.4	Thyroid	2.0	Placebo	1.8
B	76	Benzedrine	3.2	Benzedrine & Thyroid	3.7	Placebo	2.0	Thyroid	2.0
C	70	Benzedrine	4.5	Thyroid	3.2	Benzedrine & Thyroid	2.5	Placebo	2.0
D	63	Benzedrine & Thyroid	3.1	Benzedrine	2.1	Thyroid	2.1	Placebo	1.6
E	37	Thyroid	3.4	Placebo	2.8	Benzedrine & Thyroid	2.7	Benzedrine	1.8
F	40	Thyroid	3.0	Benzedrine & Thyroid	3.0	Benzedrine	2.8	Placebo	1.7
G	34	Thyroid	3.0	Placebo	2.9	Benzedrine	2.4	Benzedrine & Thyroid	2.0
H	36	Placebo	2.9	Benzedrine	2.5	Thyroid	2.3	Benzedrine & Thyroid	2.1
I	27	Placebo	2.9	Benzedrine	2.3	Benzedrine & Thyroid	2.4	Thyroid	2.0
J	29	Placebo	2.1	Benzedrine & Thyroid	2.0	Thyroid	2.0	Benzedrine	1.7

\* Placebos resembling benzedrine tablets were supplied by Smith, Kline and French Laboratories.

1. Lessem, M. F., and Myerson, A.: *New England J. Med.*, 218:119 (1938).

2. Beyer, Karl H., and Meek, W. J.: *Arch. Int. Med.*, 63:752 (1939).

3. Myerson, A.; Loman, J., and Dameshek, W.: *Am. J. Med. Sc.*, 192:560 (1936).

4. Lagen, J. B.; Soley, M. H., and Leake, T. B.: *Proc. Soc. Exper. Biol. & Med.*, 35:276 (1936).

5. Molitch, M., and Poliakoff, S.: *Arch. Pediat.*, 54:683 (1937).

6. Rosenthal, G., and Solomon, H. A.: *Endocrinology*, 26:807 (1940).

of the groups studied (irrespective of the order) was as follows:

Amphetamine Sulphate .....	2.5 pounds
Amphetamine Sulphat and Thyroid. ....	2.5 pounds
Thyroid .....	2.5 pounds
Placebo .....	2.4 pounds

416 Clinton Place

#### CONCLUSION

In 500 obese individuals on low caloric intake, amphetamine (benzedrine) sulphate, thyroid extract or combinations of these failed to accelerate weight loss over that resulting from the sub-maintenance diet alone.

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## A SIMPLE METHOD OF TIMING BLOOD COAGULATION

By C. H. KNAUER, M.D., Trenton, N. J.

An ordinary hypodermic syringe with slightly larger sized needle than ordinary is used. If necessary, the small diameter needle will serve. Blood is withdrawn from the median basilic or some other prominent vein. A few bubbles of air are drawn into syringe and the syringe is allowed to rest on its side for three minutes, after which time it is tilted slowly from end to end so as to permit the bubbles with their interspaces of blood to travel slowly from one end of the barrel to the other at one-quarter minute intervals. It is soon found that the

rapidity with which these bubbles traverse the length of the syringe becomes diminished with the formation of the clot and that one-half to three-quarters of a minute transpires between the onset of the clot formation and the actual completion of the process which is noted by the almost immobility of the bubbles.

Because of its simplicity, cleanliness and perfect accuracy in timing, I submit the method to those whose interest may be concerned as a practical office procedure.

304 West State Street

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## NEW TREATMENT FOR HAY FEVER

A new biologic treatment for hay fever and allergic rhinitis consists of eight to twelve intramuscular injections of 2 cc. each of "Coli Metabolin Tosse". The first five injections should be administered within five days. The balance may be given at intervals of one day. The preparation consists of the products of the metabolism of *Bacillus coli* found in the human intestines and grown on specific culture mediums. The pure cultures are incubated at body temperature, transplanted and, after heat killing the bacilli, diluted with physiologic salt solution. After aseptic filtration these metabolins in the clear liquid are used therapeutically. Their action on the sympathetic nervous system seems to be pronounced and to have a desensitizing effect.

Of the 75 patients treated with Coli Metabolin Tosse there was no result after six injections in 1 case, 1.3 per cent; cured, 53 cases, 70.7 per cent; and improved, 21 cases, 28 per cent. The average doses in cured cases were  $7\frac{2}{10}$ ; in improved cases,  $9\frac{1}{2}$  injections. The advantages of this method of treatment are (1) Tests to find out which allergen is a fault and are not necessary. (2) Coseasonal treatment, as soon as complaints have started, if possible. (3) Only eight to twelve intramuscular injections are needed. (4) No maintenance doses are required. (5) Hardly any reactions are provoked.—(Author's Abstract) E. J. Elsbach, New York State Journ. Med., 41:1248 (1941 Clinical Abstracts).



## THE ROLE OF THE GENERAL PRACTITIONER IN APPENDICITIS \*

By ROYAL A. SCHAAF, M.D., F.A.C.S., Newark, N. J.

In the fabulous decade of the twenties, the rapid and brilliant development of specialism in medicine gave rise to the thought that the day of the general practitioner was over. It was customary to refer to him more or less facetiously as the "Vanishing American"—one who had served usefully and well in his time but who had been outmoded by the specialist as was the horse and buggy by the automobile. The depression, however, did much to restore proper perspective. In less affluent circumstances, patients returned to the family physician, seeking attention by specialists only upon his advice. The people then realized that at least 80 per cent of their medical problems could be managed adequately and economically by the general practitioner. They realized further that in the army enlisted in the war against disease the general practitioner is the equivalent of the infantry man in a military organization—the backbone of the army, without which the more spectacular auxiliary arms are relatively ineffective. Great credit must be given to the general practitioner for substantial progress in the effort to improve the general health and well-being of the people. To mention only a few outstanding successes, we should note the great improvement in the maternal mortality record in New Jersey in the past few years, the almost total disappearance of diphtheria, the reduction in the death rate of pneumonia, the reduction of infant mortality, all of which are the direct result of intelligent, energetic and vigilant utilization of available medical knowledge by the general practitioner. The practitioner may justly take pride in his accomplishments in these fields, as well as in many others, but the record in appendicitis is much less creditable.

### APPENDICITIS MORTALITY

Although skilled surgeons and good hospital facilities are almost everywhere available, and

although the operative management and post-operative care, including the use of the new "miracle drugs", have reached a high degree of perfection, there has been little, if any, diminution in the mortality and serious post-operative morbidity of appendicitis in the past quarter century. The mortality each year approximates 20,000, or about half the number of deaths from automobile accidents, not to mention the incalculable instances of prolonged postoperative disability due to grave complications. When it is recalled that appendicitis, if recognized early and operated upon promptly should, in the theory at least, be attended by practically no mortality and only minimal post-operative morbidity, the magnitude and gravity of the problem immediately becomes apparent as a major challenge to our professional skill and diagnostic acumen.

The mortality and serious postoperative morbidity of appendicitis is almost entirely the result of delay either upon (1) the part of the patient, or upon (2) that of the medical or surgical attendant.

### DIAGNOSTIC DELAY

Delay on the part of the patient arises from a variety of causes, including ignorance, poverty, self-medication, lack of available surgical aid, and so on. The mortality among patients in this group is, to a large extent, beyond the control of the medical profession, but a substantial reduction in mortality may be hoped for following a vigorous and continuous campaign of education of the laity, through the press, radio and other forms of publicity. Although occasionally the severity of the inflammation may have been underestimated, delay on the part of the doctor is, with few exceptions, the result of failure to recognize the disease in its early stages. It follows, therefore, that only by improvement in diagnosis may any considerable reduction in the mortality and morbidity of appendicitis be attained.

\* Read before the Annual Meeting of The Medical Society of New Jersey, at Atlantic City, May 21, 1941.

## PATHOLOGY

The pathologic changes in suppurative and gangrenous types of appendicitis are essentially dissimilar. In fact, although the end result is the same, at the onset they are totally different pathologic entities. Suppurative appendicitis is in effect a cellulitis of the coats of the appendix, progressing to suppuration; while gangrenous appendicitis is primarily a gangrene of the appendix with suppuration occurring secondarily, the gangrene being due to thrombosis of the appendiceal vessels, resulting from their injury by fecoliths, over-distention, or other mechanical causes, followed by infection. Because of these distinct differences in the pathologic changes in the two types of appendicitis, there are definite differences in the symptomatology and complications of the two conditions. For example—an elevation of temperature appears early in the suppurative type; whereas, in the gangrenous type, a rise may not occur until, after many hours, secondary infection has begun. Also, as one might expect, the complication of thrombophlebitis of the portal tributaries occurs in the vast majority of instances in cases of gangrenous appendicitis.

## SYMPTOMS

Cases of appendicitis which conform to Murphy's classic description of pain in the right lower quadrant of the abdomen, followed by tenderness, muscular spasm, nausea, vomiting, elevation of temperature, and leucocytosis, in that order, present no great diagnostic difficulty and seldom escape recognition by any reasonably competent observer. Unfortunately, however, a great many cases of appendicitis, especially the gangrenous type, do not present this typical picture and thus cause our downfall.

The only constant symptom of appendicitis is abdominal pain, but there is no constancy about its point of origin, location, radiation, severity or character. Therefore, the possibility of acute appendicitis must be given serious consideration whenever abdominal pain is present, unless the appendix has been removed previously.

Local tenderness, while a very valuable sign, is not always present, or at least, is not always readily detectable, if the cecum, or the appendix, is abnormally located.

Nausea and vomiting, although usually present, are by no means constant. In no circumstances should their absence be permitted to rule out the diagnosis of appendicitis.

Elevation of temperature usually occurs early in suppurative appendicitis, but in the gangrenous type, its appearance is often delayed for many hours. In elderly or debilitated subjects, the febrile reaction may be very slight, even in severe cases of appendicitis. Incidentally, the temperature should always be taken rectally.

Leucocytosis is a helpful laboratory finding, but it is occasionally misleading, due to technical error. However, great reliance may be placed upon an accurate Schilling count, showing a marked shift to the left; but the total count often fails to indicate the severity of the inflammatory process, especially in elderly or debilitated subjects.

## SOURCES OF ERROR

In our experience, errors in diagnosis have occurred most frequently in cases in which:

(1) The cecum or appendix is abnormally placed.

(a) These organs may be situated well up in the right upper quadrant, where appendicitis will simulate gall-bladder disease.

(b) They may be located in the pelvis, thus leading to the diagnosis of rectal, bladder, or genital inflammation. Let it be emphasized that no examination of the abdomen is complete without a careful rectal examination, and in adult females, a vaginal examination as well.

(c) They may be transposed, or if the mesentery is long, may gravitate to the left iliac fossa.

(2) The appendix is retrocecal, with a point of tenderness in the loin, leading to an erroneous diagnosis of kidney stone or of pyelitis.

(3) The patient is advanced in years. Appendicitis occurs much more frequently in old people than is generally appreciated, and the

proportion of diagnostic errors in this group is correspondingly high. In elderly subjects, appendicitis is frequently insidious in its onset, causing only moderate pain, slight elevation of temperature and indefinite local signs. In such cases, the true nature of the condition may not be apparent until a palpable mass develops in the right lower quadrant. The total leucocyte count may not be increased. In fact, it may even be diminished, but an accurate Schilling count often solves the problem.

(4) The patient is a child. There is a shockingly high incidence of error in the diagnosis of appendicitis in children, in whom the disease often progresses very rapidly. It is in this group that early correct diagnosis is most urgently needed. There is an adage to be remembered here—"In children, abdominal pain, with vomiting, means appendicitis, until it can be positively excluded." A careful rectal examination is especially important in children under observation for possible appendicitis.

(5) Chills have occurred. The impression is generally held that chills do not occur in appendicitis, and that, if a chill has occurred, some other diagnosis is warranted. This idea is entirely erroneous. Chills in appendicitis are caused by emboli thrown off from areas of thrombophlebitis in the portal tributaries. If recognized and promptly dealt with by ligation of the appendiceal or ilioocolic veins, pylephlebitis, with secondary multiple abscesses of the liver, will be prevented, thus saving a considerable number of lives.

(6) The appendix is acutely obstructed by a fecolith, or a mechanical kink, acting as a ball valve, in the orifice of the appendix, permitting gas to enter, but not to escape. The appendix becomes greatly distended, and in effect, there is intestinal obstruction limited to the appendix. The symptoms in these cases differ distinctly from the classical picture of acute appendicitis, in that, at the onset, the pain is always in the epigastric region. It is very severe, and is accompanied by persistent vomiting, poor response to enemas, and little, or no, elevation of temperature. The epigastric pain is probably the result of traction on the mesentery, due to the great distention of the appen-

dix. In cases of this type, the diagnosis of intestinal obstruction is usually made, but it is a clear-cut picture to those of us who have seen a few such cases. The diagnosis hinges upon tenderness in the right iliac fossa, with a marked shift to the left in the Schilling count.

(7) Appendicitis follows the onset of pneumonia, especially in children. These cases present the greatest diagnostic difficulty, but persistent vomiting, with right lower quadrant pain and tenderness, calls for the closest observation and occasionally exploratory incision.

#### PRACTICAL SUGGESTIONS

With so many possibilities of error in the diagnosis of appendicitis, how may we improve our diagnostic record?

The following suggestions will be helpful:

(1) In the differential diagnosis of any abdominal disorder accompanied by pain, consider acute appendicitis seriously, no matter how remote the possibility may seem to be. Consider it first, last, and all the time.

(2) Do not rule out the diagnosis because of the absence of nausea, vomiting, or fever.

(3) Do not rule out the diagnosis because of the character, location, or severity of the pain, especially in children or in the aged.

(4) Do not be misled by an unusual location of the point of maximum tenderness. Remember the possibility of an abnormally located cecum or appendix.

(5) Do not fail to do a careful rectal examination in all cases.

(6) Do not fail to take rectal temperature readings.

(7) Have an accurate Schilling count made.

(8) Remember the significance of chills in appendicitis.

(9) Remember obstructive appendicitis—its onset, with epigastric pain—its resemblance to the picture of acute intestinal obstruction.

(10) Remember that in children, especially infants, abdominal pain with vomiting means appendicitis, until it can be positively excluded.



(11) Remember the possibility of acute appendicitis, as a complication of any infectious disease, especially pneumonia and tonsillitis.

(12) Remember the possibility of acute appendicitis in the aged—the indefinite character of the onset—the lower febrile reaction and the early appearance of a mass in the right lower quadrant.

(13) Remember that there is no such entity as "acute indigestion". Every abdominal pain arises from an organic cause.

Finally, if after careful observation and

study the diagnosis is still in doubt, operate. It is definitely better to remove one appendix too many than one too few.

Having stated the factors in the problem of the mortality and morbidity of appendicitis, what, then, is the rôle of the practitioner in its solution? Briefly, his rôle may be dramatized by comparing it aptly to that of the watcher on the roof-tops of London, whose vigilance and quick action in snuffing out an incendiary bomb with a little sand prevents a devastating conflagration.

413 Mt. Prospect Avenue

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## REDUCING TETANUS MORTALITY

A method of treating tetanus which resulted in a reduction of a gross death rate of 56 per cent among their patients in past years to a current rate of 29 per cent is described in *The Journal of the American Medical Association* by Albert G. Bower, M.D., and Hyman I. Vener, M.D. If the 12 patients dying during the first 24 hours of hospitalization are excluded from 100 patients treated by their new method, the net death rate among 88 patients was 19.3 per cent, the two men say.

"The prime object in the management of tetanus is to administer a minimum dose of 200,000 units of antitoxin in a definite period of 24 to 36 hours. Thereafter we refrain from disturbing the patient for a period of ten days to two weeks except for giving 1,500 units every four days in order to maintain desensitization until complete recovery or death ensues."

Treatment during the first 36 hours follows a very definite schedule. Within 30 minutes after admission they administer chloral hydrate. An hour later 20,000 units of antitoxin are injected completely around the wound. Sixty minutes later the wound is opened and all foreign material removed. The area is treated as though it were infected. In some instances, if a finger or toe is involved, it is amputated. Before any surgical intervention 60,000 units of antitoxin is injected deep into the muscle

girdling the extremity involved. Later 20,000 units of antitoxin previously warmed to body temperature is injected into the head of the spinal canal. Following this the temperature may become elevated within a few hours but it usually subsides from within eight to ten hours. When it has receded to about 102 F., 40,000 units of antitoxin diluted in a solution of sodium chloride are injected into the vein. Two hours later methenamine is given intravenously. This drug constitutes an integral part of the management; its action allows greater permeability to the antitoxin. An hour later a second intravenous injection of 20,000 units of antitoxin is administered. Approximately twelve hours after the second intravenous dose the final 40,000 units of antitoxin is injected deep into the muscle. Methenamine is given intravenously ten to twelve hours after each injection of antitoxin into the muscle.

Among other points in their program of general bedside management is the important one that patients should be kept in a quiet, semi-dark room. "A special effort should be made to avoid squeaky beds and doors, noisy elevators, beside conversations, unnecessary examinations and hospital repairs in the vicinity of the patient's room. These annoyances cause convulsions."

The average hospital stay of a patient with uncomplicated tetanus is about three weeks, they report.

## EMOTIONAL FACTORS IN BRONCHIAL ASTHMA

By J. A. HAIMAN, M.D., New York City

With full recognition of the incompleteness of our knowledge as to details, it seems clear that a neurotic predisposition underlies many cases of asthma just as it does numerous other conditions. As a rule, the neurotic tendency is familial and therefore probably inherited. Thus a hereditary "nervous instability" associated with weakness in an organ system may predetermine the type of disease from which a patient suffers. Certain disease manifestations, therefore, may be looked upon largely as personality expressions. Psychic and emotional disturbances play an important part in asthma and a number of impressive papers have called attention to this fact. Among these are the monographs of Saenger<sup>1</sup> and Brügelmann,<sup>2</sup> which go far toward establishing asthma as a psychosomatic disorder. While some such relationship has long been known, it has never fully received the consideration that it well deserves.

The Asthma Research Council<sup>3</sup> reports (a) that the results of general treatment without specific treatment are at least as good as the results of general treatment combined with specific desensitization to inhalant proteins and better than those of desensitization alone, and (b) that there is further evidence of the importance of the psychologic factor, this time in the effects of treating rhinorrhea with physiologic solution of sodium chloride alone. The startling fact was that the results were slightly better than those of protein desensitization. Thus the psychologic element was found to be of even greater importance than was anticipated.

De Bersaques and Berat<sup>4</sup> stress the importance of a constitutional factor in asthma and emphasize the occurrence of neurovegetative instability, the frequency of tachycardia, exag-

gerated reflexes and increased sphygmolability in asthmatic patients. These authors indicate that asthma does not have a single cause but that three factors are of equal importance: (a) the respiratory factor, (b) the instability of the neurovegetative system and (c) the hepatic factor. In the therapy of asthma they prefer products containing 0.25 mg. of epinephrin and from 0.03 to 0.04 Gm. of ephedrin for immediate relief. To modify the neurovegetative instability they recommend mild sedatives, particularly a combination of belladonna, ergotamine and phenobarbital. To counteract the hepatic disorders they recommend dietetic measures, choleretics and cholecystokinetics and—in some cases in which allergy is proved—methods of desensitization. They state, however, that such cases are rare, and that hypersensitivity is the result of the constitutional status rather than a causative factor.

### PHYSIOLOGIC BACKGROUND

Normal respiration is maintained by the smooth physiologic functioning of the vegetative nervous system and respiratory movements usually are carried out automatically without the intervention of voluntary processes. To a limited extent, however, the central nervous system does influence respiration and this effect undoubtedly is mediated through the diencephalon which serves as a coördinating mechanism for voluntary and involuntary processes.

Disturbances in the autonomic system in which the parasympathetic division is stimulated give rise to spasmodic seizures and logically may account for the asthmatic attack. The dominant symptoms of bronchial asthma, viz. spasm of respiratory muscles and edema of the bronchial mucosa, are manifestations of parasympathetic hyperactivity. In fact certain relationships in asthma suggest that this hyperirritability is an important factor in the causation of the disease. Thus, the reactions of the bronchi and bronchial vessels to both direct and reflex autonomic stimulation indicate that disturbances of pulmonary innervation may

1. Saenger, M.: *Uher Asthma und seine Behandlung*, Berlin, Karger, 1910.

2. Brügelmann, R.: *Das Asthma*, Wiesbaden, Bergmann, 5, vermehrte, Aufl. 1910.

3. Foreign Letters, *Asthma Research*: J. A. M. A., 112:656, 1939.

4. De Bersaques, P., and Berat, A.: *The Pathogenesis and Treatment of Asthma*. Arch. Med. Chir. de l'App. Respiratoire, 13:161-246, 1938.

lead to autonomic states and that at least some cases of bronchial asthma are to be regarded as purely neuroses. In many patients the nervous manifestations of asthma probably are the effect of low-grade inflammations of bronchial mucosa.

#### PRECIPITATING FACTORS

That asthmatic attacks may be brought about by reflex stimulation of various afferent nerves, i. e. those supplying the nasal mucosa, is well known. Likewise strong emotional disturbances not infrequently induce bronchospasm and asthmatic seizures may even be initiated in the predisposed patient by this cause. Thus, such emotions as shock, grief and worry brought about by unhappy environmental conditions such as a death in the family, business disaster, an unfortunate love affair, or loss of economic security, may result in asthmatic seizures.

The patient's fear that he is suffering from a chronic disease such as tuberculosis, cancer or lues is of great importance as a cause for asthmatic attacks. Such a fear may become an obsession with the patient. The fear of pulmonary tuberculosis is particularly prone to give rise to asthma; perhaps because both diseases usually affect the lungs.

Once an attack of asthma occurs there is a tendency to numerous repetitions of the condition so that eventually a persistent state may become established that will be difficult to overcome. The attack may be initiated, intensified or prolonged by anxiety on the part of relatives or associates. The "high-strung" wife by her undue watchfulness and exaggerated concern for the welfare of the patient may intensify the seizure by transferring her unstable nervous state or excessive "nervous energy" to the patient. Indeed an asthmatic seizure may be precipitated in a predisposed but otherwise perfectly normal patient by careless excitatory remarks. The wife, arising in the morning, may take one look at her husband and remark, "My goodness, Charlie, how terrible you look. Are you sure you feel all right; don't you think you had better get the doctor right away? You stay in bed, and don't you dare move." Immediately the poor patient begins to

wheeze and is thrown into a seizure from which it is often difficult to obtain relief.

#### ASTHMA IN CHILDREN

It is not uncommon to find that asthmatic attacks in a child are plainly "manufactured"; or at least that they have their origin in a highly excited state in the mother. In such cases the child is under the double handicap of having inherited an unstable nervous system or constitutional make-up and of being placed in an environment that is unfavorable for him. Bray<sup>5</sup> found that 50 per cent of his asthmatic patients were "only children". This is a fact of significance as to the importance of nurture in breeding asthma, because the "only child" is usually a pampered, sheltered child, and therefore liable to affections of the autonomic system; a psychologic factor is also inevitable. The frequency of asthma in the older or eldest child (who is the only child till others come) and the comparative freedom of later children, even when the family history is positive, emphasizes this.

#### OTHER AUTONOMIC SYMPTOMS

While the spasmodic state in asthma is the outstanding symptom of vasomotor disturbance, there are other manifestations referable to autonomic imbalance. Among these are: fatigue to the point where the patient is hardly able to hold up his head with a sense of greater fatigue on arising than was experienced the night before, skin eruptions of the urticarial, psoriatic and erythematous types, hyperhidrosis, diarrhea, tachycardia, post-nasal drip, swelling of the nasal mucosa, blanched mucosa, nasal polypi, and a sense of pressure in and behind the eyes. These manifestations of vasomotor instability are relieved coincidentally with the asthma when proper treatment of the underlying disturbed state is given.

#### DIAGNOSIS

A careful physical examination of the asthmatic patient together with laboratory tests, x-ray and fluoroscopic studies should be made for the obvious purpose of detecting the pathology present. A somewhat less obvious purpose

5. Bray, George W.: *Recent Advances in Allergy*. Phila., Blakeston Co., 1937.



for this meticulousness is that it is a fundamental part of the treatment to impress the patient that he has finally found a physician who takes his condition seriously. All too frequently nothing can be found to account for the patient's condition, but it will be therapeutically helpful if the asthmatic seizures can be linked to something definite, no matter how trivial. It is essential for the patient to relieve his mental state by a recitation of his symptoms, complaints and unhappy experiences. If the doctor is to be successful in the treatment he must listen to this wearisome recital with intense interest for it is all a part of the symptom complex and a full understanding of it is necessary.

#### MANAGEMENT OF THE PATIENT

In the treatment of asthma of this type, some physicians are by nature more capable than others. The doctor must impress the patient with his profound interest in the case, his thorough understanding of it and his complete confidence in the patient's ultimate recovery. The patient, once assured that he can recover, is well started on the road to regained health. It is often necessary to have a heart-to-heart talk with over-solicitous relatives, pointing out how their nervous state is being transferred to the patient and to impress upon them the necessity for full coöperation. In severe cases it may even be necessary to separate the patient from those who influence him unfavorably; this is especially true in the case of children. Therapy to be fully effective must be directed toward every phase of the condition and naturally will vary with the patient.

The reason most asthma patients have not been permanently relieved of their condition is that the physician in charge had treated only the end results and not the cause of the condition. The allergist feels that relief can be effected by giving a house dust vaccine if the patient has a house dust reaction, etc. The rhinologist regards the removal of nasal polyps, and the clearing out of the nasal accessory sinuses as the proper treatment. The psychiatrist expects, that by alleviating the patient's basic fears, he can accomplish what the others have failed to do. These separate methods are

inadequate because of the limitations of each specialized approach.

To treat an asthmatic, the doctor must be versed in all of these specialties. Comprehensive consideration must be given to the patient, his heredity and his environment.

#### TREATMENT

In initiating treatment it is most important that free nasal breathing be instituted without delay. This can be accomplished by conservative methods, not by radical operative procedures. Nasal polyps can be removed painlessly by electro-coagulation. The swelling of the middle and inferior turbinates can be relieved by ionization.

The psychologic phase can be managed only by a doctor who has studied large numbers of these cases and is able to interpret the cause of the asthmatic symptoms. The asthmatic can always give a definite "reason" for his attack. If the attending physician can determine, in his own mind, the exciting cause and is assured that no other lesion is present, he can speak positively as to the favorable outcome and at once eliminate many of the anxieties present in the asthmatic. To begin treatment and to control the nervous instability from which these patients suffer, the use of mild sedative medication as advocated by De Bersaques and Berat<sup>4</sup> has proved of distinct value.

I have repeatedly demonstrated to physicians who have studied these cases with me that one can relieve asthmatic distress as readily with normal saline as with injections of adrenalin or inhalations of adrenalin and cocaine.

By proper reassurance that the symptoms are due to certain food, bacteria, protein, etc., the therapist can often change the asthmatic wheeze into a simple cough. Then it can be demonstrated that the cough is due to a post-nasal drip, and that the drip is due to a swelling of nasal mucosa with an excessive secretion which can be controlled by treatment of the abnormal mucous membrane. The patient should not receive adrenalin or other constricting medications. Only recently I have taken two patients out of oxygen tents, and changing their medication from injection to a capsule

and given complete relief in from 24 to 48 hours.

The patient feels, however, that the new medication is more efficacious than the previous one. To prove the necessity of this I have had various sizes of sodium bicarbonate capsules made up, naming them one, two, three and four—and if it were not such a tragic affair to see an asthmatic sufferer with a prolonged attack—it would be laughable to hear him state that No. 2 capsule will relieve him, whereas No. 3 capsule will increase his symptoms. All the capsules, of course, contain sodium bicarbonate. I had another patient who felt that he could be improved only by injections, and when I changed the injection from normal saline to saline and 0.5 per cent glucose, telling him at the same time that a stronger injection was given, the patient slept more quietly than after the injection of adrenalin.

After having labored ineffectively for some little time under the belief that asthma was due to a protein reaction or other sensitivity, I became convinced a number of years ago that it had a neurogenic basis. If one can remove the anxiety phase the swollen membranes will disappear through the action of the sympathetic nervous system. Alvarez<sup>6</sup> has so aptly stated this in his writings that one must accept this fact.

Kennedy and Wortis<sup>7</sup> have recently demonstrated that migraine and epilepsy definitely come under the mediation of the sympathetic

nervous system. Deutsch<sup>8</sup> states that asthma definitely has a neurogenic basis.

Some clinicians feel that only a few cases of asthma are of this type and that most cases can be relieved when the "allergic cause" is removed. This reasoning places the cart before the horse, for there must first be a "nervous shock" in a sensitive individual before he will react to any of the offending proteins. Later when the patient is relieved of all symptoms including the basic anxiety he will not react to the allergin as formerly.

#### SUMMARY

1. Bronchial asthma, vasomotor rhinitis and related states are often symptoms of vasomotor imbalance.
2. A "neuropathic constitution" predisposes the patient to functional disorders of which the asthmatic state is an example. Emotional upsets and unfavorable environmental factors are precipitating causes.
3. Successful treatment of asthma begins with the restoration of normal breathing and the giving of appropriate sedative medication to modify favorably or to stabilize the underlying "neuropathic terrain".
4. For lasting results, disturbed psychic states and unfavorable environmental factors must be corrected and improvement expected in diet, habits of rest, work and exercise. The physician must be sympathetic and able to inspire the patient with confidence in his full recovery.
5. All physicians are not equally suited temperamentally for the treatment of these patients, hence some will secure better results by the method described than others.

6. Alvarez, W. C.: *An Introduction to Gastro-Enterology*. New York, Hoeber, 1940.

7. Kennedy, F.; Wortis, S. B., and Wortis, H.: *A Research Nerv. and Ment. Dis. Proc* 18:670-681, 1938.

8. Deutsch, Felix: *An Address before the Association for Research in Nervous and Mental Disease*, December, 1938.

## RELATION OF THE GENERAL HOSPITAL TO PSYCHIATRY

By J. BERKELEY GORDON, M.D.

Medical Director, New Jersey State Hospital, Marlboro, N. J.

Address delivered before New Jersey Hospital Association, Atlantic City, May 17, 1941

Hospitals are not ordinarily regarded as business enterprises in the sense of being money-makers to earn dividends on invested funds to stockholders or individual owners. Such a concept of the hospital indeed violates a fundamental meaning of the word which originally signified a place of hospitality and entertainment for guests or travelers, and later a place of refuge and free treatment for the sick and injured. Hospitals are expected to pay dividends to the people and to the communities that they serve in the relief of pain, the saving of lives, and improved health, in its larger sense.

The term General Hospital, as ordinarily used, is a misnomer. Most "general" hospitals restrict their patients to certain types and exclude certain illnesses which they regard as undesirable because of lack of facilities, personnel or material, or because the presence of patients suffering from these diseases is esthetically objectionable to other patients in the hospital. Among such diseases frequently excluded from general hospitals are the acute contagious and epidemic diseases; venereal diseases in a transmissible stage; chronic diseases of the body with a poor prognosis, such as inoperable carcinoma, spinal sclerosis, etc., and mental diseases. Sufferers from these disorders, however, constitute a major medical and public health problem, and deserve the thoughtful attention of hospital executives and workers.

### EXTENT OF MENTAL DISEASES

To illustrate the enormity of the mental disease problem alone, it is noteworthy that of the approximately one million hospital beds of the country a little more than half of them are occupied by victims of mental disease alone. Furthermore, it is significant that while many general hospitals operate with vacant beds (vacancies reaching 50 per cent in some of the smaller institutions), the public mental hospitals of the country are uniformly

overcrowded, the disparity frequently ranging as high as 50 per cent more patients than their proper capacity.

### ADVANTAGES OF A PSYCHIATRIC SERVICE

Now, while voluntary hospitals are not expected to make a profit from the communities that they serve, there is no objection to their reducing operating losses to a minimum, nor is it considered unethical for hospital executives to decrease their deficits and approximate the balanced budget. We believe that the operation of a psychiatric division in many general hospitals will materially improve both the quality and quantity of service they render their communities; that such psychiatric services will function as valuable and much-needed centers of education both to the lay public and to the professional staff, thus indirectly improving the standards of public health; and that such services will be economic assets rather than liabilities to the general hospitals providing them. This latter thought is worth considering especially for hospitals having a number of unfilled beds during a part of the year at least, and a good deal of red ink on the annual balance sheet.

### THE ALLEGED STIGMA OF MENTAL DISEASE

While the public attitude toward mental disease is slowly changing, and while these diseases are gradually being recognized as analogous to physical disorders, it is still true that commitment to a mental hospital is regarded as a stigma to the patient. It is also true, however, that there is a large public demand for efficient psychiatric treatment at moderate cost in general hospitals, as distinguished from the high degree of physical comfort or even luxury obtaining in some private sanatoria where both medical and psychiatric treatment are practically nil and where the cost to the patient is so great that the clientele is limited to the well-to-do or to those having access to public grants and benevolences.



## PSYCHIATRIC ASPECTS OF GENERAL PRACTICE

Varying estimates indicate that from 35 to 65 per cent of the problems presenting themselves to the average general practitioner require psychiatric and personality understanding. Strecker estimates that 75 per cent of the clientele of the general practitioner during the first ten years of his professional life consists of neuroses, organic conditions complicated by neurotic disturbances, psychopathologic complications of chronic organic disease, the mental aspects of convalescence, and psychopathologic problems in children. Although fewer than a hundred general hospitals in the United States have provision for the care of nervous and mental patients, every general hospital admits psychiatric patients without knowing it, and they are usually treated without any consideration of the psychiatric issues. Great numbers of paretics, post encephalitic neurologic and behavior disorders, alcoholics, emotional disturbances at the menopause, psychoneuroses, simple adult maladjustments, and various behavior and personality disorders of a pre-psychotic character in children, to name but a few, could in many instances be successfully treated in the psychiatric division of a general hospital at an early point in the process before it becomes quantitatively severe enough to compel commitment to a State Hospital by reluctant relatives.

Many useful citizens could be saved by treating such conditions early before they have become frank psychoses, and like the neglected cancer, spread to a hopeless and inaccessible extent throughout the mind. With the development of shock therapy, an entirely new outlook has developed for the mental patient. Even for victims of demential praecox, a mental disease formerly having a very poor prognosis, the outlook is now decidedly hopeful if treatment is administered early. There is no reason why shock therapy in the hands of competent and well-trained psychiatrists should not be used in psychiatric divisions in general hospitals. Many victims of a malignant mental disease could thus be saved from commitment and the hopeless prognosis born of prolonged neglect. Moreover, much unnecessary expense to the county can be saved by avoiding the

legal commitment of certain patients whose mental illness is of brief duration and clears up quickly under conservative therapy in a general hospital. In most communities, there is no place for the emergency psychiatric patient to go while commitment is being arranged, except the jails. This is illogical, inhumane, and poor hygiene in every sense of that word.

## EDUCATIONAL VALUE

As an educational force both to the community and to the hospital's professional staff, the psychiatric division has much to commend it. The layman's idea of a mental patient and a psychiatric hospital is still pathetically close to the old pictures of Bedlam. This is even true of well-educated, civic-minded organizations whose members pride themselves on their knowledge of current problems. It is discouraging, at the end of a lecture to groups such as these, when questions from the audience are invited, to have their total misconception of the problem betrayed by some question which indicates that the points you have so carefully and painstakingly hammered home have been missed completely. For this reason I feel that the question-and-answer period after a talk is often the most valuable part of it, since it gives the speaker a chance to estimate the amount of information possessed by his audience and to correct specific misconceptions.

The ideas of the general practitioners of medicine, and of non-psychiatrically minded specialists about psychiatry are scarcely less medieval than those of the lay public. A few years ago I went to the trouble of reading a paper on "The Mechanism of Committing Mental Patients to State Hospitals in New Jersey" to a County Medical Society, and following the meeting I mailed a reprint of the paper to every doctor in the county. Despite this small candle in the dark, my colleagues continue to make the same unfortunate, ludicrous, and sometimes expensive mistakes.

The "supposed cause of the insanity", for example, is still given in some instances as "cigarettes and masturbation";—a good friend of mine solemnly swore that he made a personal examination of the patient on a certain

date, on which date, it was easily proved in court, he was in a plaster cast with a broken vertebra, and had not been within twenty miles of the patient, nor had he seen the patient for some weeks at all;—a Past President of a County Society tried to commit a mentally ill patient, who was entirely unwilling to enter the hospital voluntarily, on his prescription blank;—another friend solemnly asserted that the physical condition of the patient was "Good" when the patient was found to have a lobar pneumonia with temperature of 105° on admission and died eight hours after entering the hospital. The inhumane custom of committing a moribund patient to a mental hospital still exists, as we have good reason to know. The list need not be prolonged: it is too depressing. It erves to demonstrate, however, how otherwise good and useful doctors resist and avoid education in psychiatry when they pride themselves on keeping abreast of developments in other fields.

A psychiatric division in the general hospital will go far toward educating the Staff in this neglected subject, and making the doctors conscious of the emotional attributes of somatic disease. In this connection it may be said that we have found the "Affiliate Internship" definitely worth while. In this project, each intern at a nearby general hospital spends two months of his eighteen months' rotating service at the Marlboro State Hospital affiliating in psychiatry. He goes back to his general hospital conscious of the psychiatric principles he has learned, and applying them in his work. He goes out into the community to practice medicine with an exposure to post-graduate education in this field and a knowledge of where to go and what to do when he encounters psychiatric problems beyond his capacity. Perhaps most important of all, he learns to recognize the problem when he encounters it. For general hospitals unable to establish a psychiatric division, I urge the consideration of the "Affiliate Internship" in the training of their young doctors, and affiliation in a psychiatric hospital for their student nurses. The train-

ing they receive is valuable to them and to their patients. Incidentally, the "affiliate internship" provides a source of junior physicians to the psychiatric hospital, since they have had a chance to demonstrate their natural ability and interest, or lack of it, during the affiliation.

#### ORGANIZATION

In a recent communication, Davidson<sup>1</sup> has emphasized the mental hygiene mission and contribution of the general hospital. To say that mental hygiene is a specialized job for which general hospitals have no facilities is to evade part of your responsibility, says Dr. Davidson. More mental hygiene clinics should be employed as a regular part of the out-patient department of the general hospital and more use should be made of the psychiatric personnel in these departments for "in-patient" mental and personality problems.

Ebaugh<sup>2</sup> recently reviewed this subject thoroughly and described three satisfactory plans for the organization of the psychiatric division in a general hospital, viz: (a) A consultation service, (b) a psychiatric subdivision within the department of medicine and (c) an independent department of psychiatry. Heldt,<sup>3</sup> in several communications, has discussed the organization, administration, architecture and other aspects of the subject.<sup>4</sup>

#### CONCLUSION

The general hospital needs to participate more in psychiatry; psychiatry needs to penetrate more into general hospitals as a regular and accepted part of the institution's service to its community. In this way a larger direct contribution will be made to public welfare and health and a still greater indirect contribution will be made by training professional personnel in the specialty of psychiatry.

1. Davidson, Henry A.: "Mental Hygiene and the General Hospital." *Journ. Med. Soc. of New Jersey*, 38:173, April, 1941.

2. Ebaugh, Franklin G.: "Care of the Psychiatric Patient in General Hospitals." *American Hospital Association*, 1940.

3. Heldt, Thomas J.: "Treatment of Mental Diseases in a General Hospital." *New York State Journal. Med.*, 30:63 (Jan. 15, 1930).

4. Heldt, Thomas J.: "Psychiatric Services in General Hospitals." *Am. Journ. Psych.*, 95:865 (Jan., 1939).

# STATISTICS ON ECTOPIC, OTHER ACCIDENTS OF PREGNANCY, OTHER UNSPECIFIED CONDITIONS, AND EMBOLISM AS CAUSES OF MATERNAL MORTALITY IN NEW JERSEY

## MATERNAL WELFARE ARTICLE NUMBER SIXTY-SEVEN

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and  
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,  
State Department of Health

This is the seventh and last article on New Jersey Maternal Mortality Statistics for 1940.

### ECTOPIC GESTATION

Up to 1933, deaths from ectopic gestation were classified with "Other Accidents of Pregnancy". In that year they were given a separate classification. The same was done with abortions.

On studying the graph, No. 21, it will be seen that the rate is about the same for the last three years, 1.7 per 10,000 live births. The rural rate (the dotted line) is apparently a little lower than the urban (the broken line) each year.

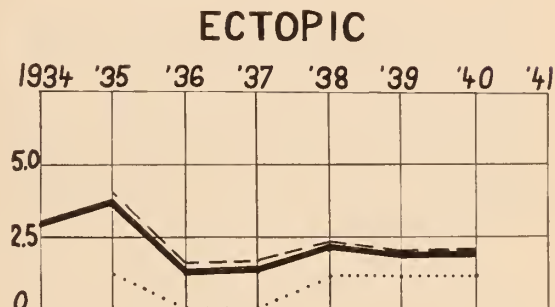
Three of the patients had infection and seven had none. Six patients were white and four colored. Operation was delayed too long in several cases, sometimes due to inability to secure the patient's consent and sometimes due to delay on the part of the physician. Incomplete histories made it impossible to tell what gravida or para the patients were. This question is not asked on the Children's Bureau form which is used for investigation of maternal deaths and the field physicians do not as a rule state it. This should be added and will be taken up with the authorities for it is valuable information in a study like this.

A very brief history of each case in this group is given below.

Case 153.—White. Age 30 years. Four months' gestation. D & C. Abdominal operation refused until later when it was too late. Patient died one month after operation.

Case 109.—Colored. Age 28 years. According to dates, full term. Induction of labor attempted four different days, finally by laparotomy delivered macerated foetus from abdominal cavity. Streptococcus infection in wound. Patient died 18 days after operation.

Case 110.—White. Age 34 years. Pregnancy two weeks. Had what was considered prolonged menses, 8 or 9 days, then sudden pain. Rushed to hos-



pital and operation at once. Died at completion of operation. Shock and hemorrhage.

Case 111.—White. Age 32 years. Gestation 6 weeks. Sudden pain and shock. Operation in 4 hours. Patient failed to rally.

Case 117. Colored. Age 31 years. Gestation 4 weeks. Sudden abdominal pain. Advised to go to hospital. Refused. Died that night without any treatment.

Case 128.—Colored. Age 24 years. Gestation 3 months. Grav ii, para i. Admitted to hospital with the diagnosis of acute appendicitis on account of pain in lower right quadrant for 2 days. Operation showed ruptured ectopic. Good recovery with a slight temperature. In going to bed from a chair on second day out of bed, patient suddenly died. Embolus. Death occurred on the tenth day post operative.

Case 146.—White. Age 29 years. Gestation 6 weeks. Severe lower abdominal pain. Shock. Two transfusions given followed by operation. Died few hours later.

Case 46.—White. Age 35 years. Gestation 6 weeks. History of vaginal bleeding for 3 weeks. Admitted in deep shock. Given glucose and whole blood but became progressively worse and died before operation.

Case 14.—Colored. Age 24 years. Gestation 3 months. Physician made diagnosis of threatened abortion. Admitted to hospital in shock. Transfusion and prepared for operation. Died before operation. In hospital 11 hours.

Case 5.—White. Age 31 years. Gestation 2 months. Operation followed by paralytic ileus, unilateral parotitis, and finally pneumonia. Patient died 12th day post operative.



## OTHER ACCIDENTS OF PREGNANCY

There were three deaths in this classification. As this group is small, no graph nor map has been prepared. These deaths occur before delivery. The most common complication is heart disease. Hydatidiform mole accounted for one death. Brief histories follow:

Case 157.—Grav vii, para vi. Age 34. White. Midwife case. Death probably due to heart disease with exhaustion during labor. Gestation 9 months. Patient died after 11 hours of labor.

Case 78.—Gravida not stated. White. Age 22 years. Hydatidiform mole. Bleeding occurred during 5 weeks before admission to hospital. D & C twice for mole. Patient died few days later.

Case 73.—Gravida not stated. Colored. Age 23 years. Membranes ruptured at term. Patient died before labor started. Heart failure. Had attended prenatal clinic regularly. Slight mitral murmur had been noted prenatally.

## OTHER UNSPECIFIED CONDITIONS

There were five deaths in this group. They all occurred after delivery. Heart disease is again the most common complication. Psychoses are included in this group if there are no other complications which place them in another classification.

Heart disease is frequently a serious complication and in every case a careful study must be made of the patient to determine whether it is safe for her to try to go through her pregnancy. This is often very difficult to decide. Some patients with a marked valvular disease will go through pregnancy without any trouble while another with apparently a slight abnormality will succumb. If it is decided to allow the patient to go on she must be carefully supervised throughout pregnancy. Rest in bed is generally needed at the first sign of decompensation and in this way many patients may be carried successfully to term; however, if allowed to go about as usual without supervision, the patients are likely to become worse suddenly and may die before delivery or soon after.

Brief histories of this group follow:

Case 150.—Grav iv, para iii. Age 29 years. White. Gestation 8 months. Myocarditis. Tuberculosis. Nephritis. Autopsy. Stillbirth. Patient died immediately after low forceps delivery.

Case 116.—Grav iii, para ii. Age 32 years. White. History of scarlet fever, chorea, and heart disease. Treated for 4 months in bed in hospital. Developed acute heart failure, delivered a living child, and in a few hours died. Spontaneous delivery, no anesthesia. No autopsy.

Case 113.—Grav x, para ix. Age 44 years. White. Gestation 6 months. Prenatal care throughout pregnancy. Rheumatic heart disease, nephritis. Breech delivery. Stillbirth. Apparently in labor about 2 days. Died 4 days post partum.

Case 102.—Grav i, para 0. Age 22 years. White. Rheumatic endocarditis—onset in childhood. Gestation 9 months. Acute decompensation after 3 hours of labor. Patient died during midforceps delivery. Live baby.

Case 49.—Grav ii, para i. Age 35 years. White. Rheumatic endocarditis. Gestation, full term. History of rheumatic fever before pregnancies. Live baby delivered normally. Patient died 3 week post partum.

## EMBOLISM

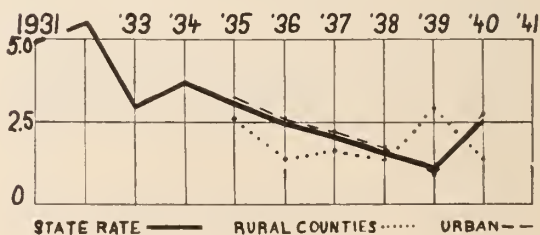
The international classification of maternal deaths now includes embolus as a variety of septicemia, but as these cases all have a common symptom, sudden death, they are considered here as a separate group.

Deaths from embolism increased in 1940, making a rate of 2.5 per 10,000 live births, double that of 1939. In two cases the diagnosis of cerebral embolism is given. The others are all pulmonary embolism which, of course, is much more common.

A brief study of these cases will show that the underlying cause of the embolism varies considerably. It is generally assumed in these cases that nothing can be done to prevent the death. When the embolism occurs there is very little to be done; but, the better condition the patient is kept in, the fewer cases of embolism we will see. Thus, there is a place for preventive treatment.

The patients were all white and most of them were over 32 years of age. Ten patients were

## EMBOLUS



primigravida, four multigravida, and two histories did not state.

Brief histories of these cases follow:

Case 3.—Grav ii, para i. Age 34 years. Period of gestation, full term. Normal delivery. Live baby. While sitting up felt faint, died in a few minutes, 10th day post partum. Autopsy: Large embolus filling the entire pulmonary conus. All other findings entirely normal.

Case 6.—Grav i, para 0. Age 42 years. Gestation, term. No prenatal care. Varicose veins. Thrombosis of leg without rise of temperature following normal delivery. Live baby. Ninth day post partum patient went home in cab and dropped dead on entering home. Autopsy showed large pulmonary embolism.

Case 28.—Grav vii, para vi. Age 42 years. Gestation 9 months. Operated on for acute appendicitis at 3 months. Had 3 prenatal visits. Blood pressure 130/90. Labor 8 hours, normal delivery. Died suddenly immediately after. Live baby.

Case 32.—Grav i, para 0. Age 39 years. Cesarean for fibroid uterus. Live baby. Patient died suddenly 10th day post partum.

Case 47.—Grav ii, para i. Age 28 years. History of sudden attacks of headache followed by nausea and vomiting. None during pregnancy. Systolic blood pressure 140 twelve days prior to delivery. Diastolic pressure not taken. Low forceps delivery. Live baby. Remained in hospital 10 days. Patient died suddenly 24 days post partum. Cerebral embolism.

Case 75.—Gravida not stated. Age 34 years. Died suddenly in the ninth month of pregnancy. Pulmonary embolism.

Case 83.—Grav i, para 0. Age 28 years. Gestation 9 months. Prenatal care started in 3rd month. Confined to bed practically all of her pregnancy because of endocarditis. In 4th month had cerebral accident followed by aphasia. In labor when admitted to hospital and cesarean done immediately. Post operative condition good except for slight afternoon rise of temperature. Live baby. Patient died suddenly 4 days post operatively. Cerebral embolus.

Case 112.—Grav i, para 0. Age 38 years. Prenatal care started in 5th month. Gestation 9 months. Blood pressure varied from 140/88 to 174/100. Medical induction. Labor 6 hours. Low forceps delivery. Live baby. Afebrile course except one day, 99.6. Seventh day was gotten out of bed and suddenly became cyanotic and died. Blood pressure day of death 140/84.

Case 121.—Gravida not stated on history. Gestation 2 months. Had been treated in hospital 9 days for pernicious vomiting, and was about to leave when patient suddenly slumped in her chair. Died in a few minutes.

Case 124.—Grav i, para 0. Age 32 years. Gestation 9 months. Prenatal record normal. Normal delivery. Episiotomy. Live baby. Third day post partum was awakened from sleep by severe pain in chest. Blood pressure at this time 190/80. Diagnosis pulmonary embolism. Discharged from hos-

pital on 18th day. Remained in bed at home 3 weeks. Died suddenly 11 weeks post partum. Day of death had been out walking.

Case 136.—Grav ii, para ii. Age 38 years. Gestation 9 months. Labor 31 hours. Brow presentation. Apparently normal before delivery. Six hours after delivery became cyanotic and died. Stillbirth.

Case 139.—Grav i, para 0. Age 33 years. Gestation 9 months. Physician stated prenatal history normal. Midwife engaged for delivery. Patient fainted during mild labor and died in ambulance on way to hospital.

Case 149.—Grav i, para 0. Age 39 years. Gestation 8½ months. Toxic 4 days. Cesarean. Live baby. Gradual rise in temperature. Sixth day post partum patient complained of sudden severe pain in chest, shortness of breath, and died suddenly.

Case 155.—Grav i, para 0. Age 24 years. Gestation 9 months. Normal delivery and post partum course at hospital. Third day home patient had chill and rise of temperature. Next day complained of pain in lower right iliac fossa. Tender on deep palpation. Diagnosis parametritis. Responded to treatment and apparently cured. Twelve days later temperature and symptom free. Twenty-five days post partum complained of full feeling at sternum and suddenly died.

Case 156.—Grav i, para 0. Age 36 years. Cesarean following 24 hours of labor with no progress. Live baby. Patient seemed well on road to recovery until 7th day when she suddenly died while nurse was changing her position.

Case 168.—Grav i, para 0. Age 26 years. Gestation 9 months. Normal delivery. Live baby. Post partum course uneventful until 8th day when patient complained of pain in left lower thoracic area. Pain gone next morning. Patient kept in bed. Tenth day patient reported pain in right lower thoracic area. Temperature 103 and physical signs of pneumonia. Temperature normal 13th day. On 16th day patient told she might sit up next day. On 17th day, 3 hours later, patient collapsed and died suddenly.

#### COMMENT

This article concludes the statistical study of maternal mortality in New Jersey for 1940. It has been recorded in more detail than formerly with the idea that physicians interested in obstetrics would like to know just what the complications were that caused the maternal deaths.

Hospitals have found the obstetric record book of great assistance in preparing their annual reports. It is the most complete book of its kind and is used by 85 per cent of the hospitals and maternity homes in New Jersey. By keeping this record any information regarding obstetric cases can be obtained in a few minutes.

The hospital has a responsibility in helping

to reduce maternal mortality. Its obstetric procedures must be supervised by competent obstetricians and rules for routine procedures and consultations enforced.

The nurse in the field also has a responsibility because frequently she is the only worker in close contact with the patient.

Patients must learn to arrange for prenatal care early and continue it throughout pregnancy.

Physicians must give more attention to detail in giving preventive prenatal care to even the simplest case. Keeping the normal case normal will improve our statistics a great deal.

Only through the excellent coöperation of the hospitals, physicians, nurses, and the State Department of Health has it been possible to make this study and it is greatly appreciated by the Committee on Maternal Welfare of The Medical Society of New Jersey.

144 Harrison Street

## A LESSON FROM A DEATH CERTIFICATE

### NUMBER THIRTY-EIGHT

Patient, a primigravida, not seen by a physician until the ninth month. A Wassermann was done, blood pressure taken, and urine was examined. Physician did not make a pelvic examination as it was late in pregnancy and he feared infection.

Patient was in labor 30 hours when the uterus ruptured and patient died. It was then

found that there was a fibroid low in the pelvis obstructing labor.

Some of us believe, that if proper precautions are used and sterile rubber gloves are worn, it is safe to make a vaginal examination late in pregnancy. Often valuable information is obtained.

A. W. BINGHAM, M.D.

## THE MOTHERS' CHARTER

Every potential mother envisions the pleasures and obligations of creating and sustaining new life and is entitled to health and protection for the benefit of herself and humanity and she should have:

1. The inherent right to be well born without inherited or transmitted defect or disease.
2. The inalienable right to protection from disease and harmful influences.
3. The opportunity to learn and know herself during adolescence and maturity and to acquire a knowledge of the origin and significance of human life.
4. The right to protection from pitfalls of married life and to a knowledge of its significance to herself and her potential family.
5. The privilege of proper premarital and pre-conceptional medical examination and advice and care for herself and her mate.
6. The right of proper and adequate care during pregnancy.
7. The right to receive adequate and necessary care during labor in her home or hospital.
8. The right to have appropriate care following labor in her home or hospital.
9. The right to secure proper and continuing subsequent care for herself and baby.
10. The right of preservation of health and life and happiness for herself and family.

This charter was formulated by the American Committee on Maternal Welfare, 650 Rush Street, Chicago.



## STATE ACTIVITIES

### WELFARE COMMITTEE MEETING

The Welfare Committee of The Medical Society of New Jersey met in Trenton, January 18, 1942. The Chairman, DR. HILTON S. READ, called the meeting to order at 2 p. m. and introduced DR. THOMAS K. LEWIS, President of The Medical Society. Dr. Lewis' talk (in abstract) follows:

DR. LEWIS: Last fall we outlined activities for the current year which revolved about medical military preparedness. Since that time, as a result of Pearl Harbor, what was a premonition has come to be a reality. The nation is now faced with the dual task of supplying the combined democracies of the world with huge quantities of planes, tanks, guns and ships and of raising the largest army of our history. This Gargantuan task calls not only for huge expansion of military forces but also for the formation of an army of industry, the like of which has never been known before. The manning of a large army and navy, the creation of this huge industrial army and the expenditure of fabulous billions of dollars cannot but cause acute dislocation of our social and financial economy.

The medical profession cannot hope to pursue its course serenely without considerable disturbance. It is estimated that before the battle has been won that there will have been called into service an army of anywhere from six to ten million men. The staffing with medical officers of this huge army will take approximately all of the young doctors and many of the older ones from civilian life. It will leave for those who stay at home a superhuman task. It will necessitate the creation of many services that heretofore the medical profession has struggled to avoid. It is fair to predict that for the duration of the war what we know as the private practice of medicine will completely disappear.

We are presented, as a profession, with the opportunity of executing an undertaking of national importance. For the first time in the history of the present administration it has been frankly conceded that, in things medical, organized medicine can best accomplish the desired results. For the sake of posterity and for the future of American Medicine, it behooves the profession to rise to the occasion. This will mean the sacrifice of personal ambitions, comfort, selfish considerations and even economic security. Every physician must hold himself ready to serve in that capacity for which his ability, physical condition and professional status fits him. The interest of groups, creeds, and races must be subjugated to the larger needs of the Nation. The medical profession, as an organized group, and in a democratic way, will be called upon to

take part in certain services which in the past we have learned to abhor.

In the present situation we can thank that group of doctors, who, for the past three years, have been working so assiduously, often in the face of criticism, toward the development and establishment of the Medical Service Administration. Through this agency we can expect confidently that the management of any new governmental services will be conducted in the best interests of the public and of the physicians and in such a manner that the American Way of the practice of medicine may be preserved.

My message today is a plea that all of your subcommittees and advisory committees apply themselves unreservedly to the serious task at hand, continue arduously in the prosecution of their program and follow through along any new line that war-time emergencies might demand. It is the time for the medical profession to prove that it can do an outstanding job, not only in self-protection, but also for the preservation to the world of democratic medicine, in the advancement of scientific endeavor and in the promotion of the health and welfare of the American people.

DR. READ reported that on January 16, 1942, the Atlantic County Medical Society welcomed DR. MORRIS FISHBEIN, Editor of the Journal of the American Medical Association, as its guest speaker. Prior to the dinner, a number of the leaders of The Medical Society of New Jersey attended a dinner for Dr. Fishbein. Purpose of the meeting was to show the headquarters of the national association in Chicago that we in New Jersey are united. That purpose was accomplished, and indicated that we, in New Jersey, will cooperate in every way so that this war will be won. There is still room for a minority to speak out in this democracy. That is the single pledge we made.

DR. LEROY A. WILKES supplemented Dr. Lewis' remarks as follows:

DR. WILKES: Civilian care during the emergency is, by Presidential decree and Congressional action, made a governmental responsibility. In conformity with this action an organization has been set up, vesting control in the Governor, and through him to the Mayor or other governing body in each of the 567 municipalities of New Jersey. These local governing bodies may request through the local civil defense committee that the medical aspects center around hospitals. The medical profession will, in turn, set up means to protect the municipi-

pality according to local conditions. The power, however, remains vested in governmental hands and is subject to their direction and approval. The organization is good, the funds can be made adequate, and the personnel has been well chosen. Equipment and supplies are assured and quarters will be made available.

Illness and injuries, as they affect the citizen during the emergency, are provided for, probably better than ever before. This is a desirable wartime provision. It is pertinent, however, to point out that with little change this same organization can serve as an operating basis for the switch over to state controlled medical practice. Governmental leaders and the President himself have assured Dr. Fishbein of the A. M. A. that no such intent is contemplated. The possibility is mentioned here as basis for the suggestion that fullest coöperation of the profession be given to civilian defense efforts, and that any criticism offered should be in the form of constructive suggestions, sent through regular channels of the Medical Society to the A. M. A. The A. M. A. will forward them to the governmental agencies so that they will be viewed as constructive efforts and not be misinterpreted as attempts to interfere in the war effort in which we are now all engaged. It would reflect upon the profession if such criticisms were voiced publicly before the government has been advised in a constructive manner, as evidence of our support and contribution.

#### MEDICAL PRACTICE COMMITTEE

DR. REUBEN SHARP, Chairman of the Committee on Medical Practice, reported on the activities of that committee. See page 99, this *Journal*, for the report.

#### PUBLIC HEALTH COMMITTEE

DR. STANLEY NICHOLS, Chairman of the Committee on Public Health, reviewed the activities of that committee, reported on page 102, this *Journal*. Dr. Nichols also made the following supplementary remarks (in abstract):

DR. NICHOLS: We all know we have to become efficient; that will be hard for some of us. From the public health viewpoint it is important that we have representation by adequately qualified members of our profession on the State Board of Health so that we will be well represented there. This has led us into difficulties due to political situations.

Before the war work began by the health and welfare organizations of this state and the allied medical professions for two purposes: (1) To study the qualifications of Board members; (2) to review the public health needs in New Jersey. We now have three excellent groups in the New Jersey Welfare Council, the New Jersey Health and Sanitary Association and the Conference of Allied Medical Professions working on the health needs of war

times in this state. They will be ready with recommendations within a few weeks.

There is a movement to make cancer a reportable disease in New Jersey. The committee was in favor of this action before the meeting this morning but, at the meeting after restudying it, in view of the absence of the Chairman of the Cancer Control Committee and the opposition which was raised to it, we thought it best to postpone action until the Chairman of the Cancer Control Committee, who brought this into being, could be present and present it to the Welfare Committee.

I have sent the following communication to the Chairman of each of the Advisory Committees:

"In view of our country's entry into the war, will you please carefully examine the objectives of your committee, with one question in mind, namely

"Is this or that activity of my committee making an essential contribution toward winning the war?"

If the answer is "No", please lay that activity aside for the duration of the war and concentrate intensely on the activities of your committee which contribute most directly to the maintenance of essential health in the military and civilian population of New Jersey.

Please give this matter your careful consideration and come to the meeting of the Public Health Committee prepared to make a three-minute report covering—

1. Progress to date of your committee as to specific objectives already stated;

2. The changes deemed necessary on your committee's program which would or will contribute vitally to the winning of the war.

The Public Health responsibilities of our committee and our Advisory Committees, together with our coöperation with Dr. Schlichter's Medical Preparedness Committee, will be at least doubled by wartime needs, and we must take prompt and forward steps to make our various Public Health programs and the participation of the members of the State Society efficient to the nth degree and keep them highly efficient during the war if victory is to be achieved and the private practice of medicine continued. We must prove that private physicians, in wartime, can carry on wholeheartedly in the meeting of all Public Health and Medical Care needs of our people. To achieve this, our committee and Advisory Committees must lead the way, lay aside all nonessentials, and make efficiency our watchword.

Let our slogan be—

"The all-out participation of the members of The Medical Society of New Jersey in Public Health and Medical Care programs for the winning of this war."

From the health and medical standpoint, this differs from all previous wars in that it is essentially a war of opposing ideas, and not, as it seems, a war of airplanes, tanks, armies and navies. It has now become clear that the nations fighting for the perpetuation of human freedoms and civilization as we have known it are led by the good ideals which have been slowly and painfully evolved



by human kind since man first crawled out of the paleolithic ooze and became civilized.

The nations at present seeking to destroy human freedoms and cause our civilized world to revert to pagan barbarisms are led by degrading, evil ideas, which viciously express themselves in all conceivable forms of wicked crimes against humanity and civilization.

Thus, from the standpoint of the physician, the world today is in the position of a mentally sick man, in whose mind the struggle between good and evil has reached a crisis. The outcome of this primarily mental struggle will either immeasurably improve human kind and the humanities, or will plunge the world into a new and worse form of the Dark Ages.

Therefore, in order to do our share toward preserving human freedoms and the American way of life, we must carefully state the Public Health responsibilities of physicians in this war.

Only a healthy people—sound in body, mind, and soul—can hope to succeed against the type of warfare our treacherous foes will wage. Upon the shoulders of the medical and allied professions falls the responsibility of keeping our people fit.

In this connection, let us be reminded that our enemies possess to a high degree physical fitness and mental courage. They lack at present high ethical and spiritual ideals. To win this war, we must match them in physical fitness and mental courage, and, like England and some other nations, defeat them by better morale gained through high ethical and spiritual ideals. For these same reasons, and with these same weapons, our forefathers established and defended this American way of life.

Nor can we physicians do all of this all-out public health job alone. For physical fitness in both our military and civilian population, we and our allied health professions and all agencies, both military and civilian, are now working together, establishing a sound foundation for physical health.

For mental courage we must work with the schoolmasters and all other groups that promote good mental philosophy and balance and courage.

For high ethical and spiritual ideals and consequent high morale, we must work with the clergy and religious bodies, who, throughout all the ages have inspired men in wartime, like Cromwell's Ironsides, to rise above their usual selves and become invincible in spirit.

The glory of the medical profession throughout the centuries has been in its traditions of self-sacrificing service for the benefit of the health of mankind. Let us follow in the footsteps of our medical forebears in New Jersey. Let us assume, joining together with health professions, schoolmasters, clergy, and all necessary groups—in an over-all health program, our full share of Public Health responsibility as physicians, for the winning of this war, whatever the cost.

Therefore, let us shoulder our rightful Public Health responsibilities, and for the duration of this war, discarding all nonessentials, keep our eyes firmly fixed on our all-out wartime public health objective, namely—to build up and maintain in the people of New Jersey a high degree of sound health

in body, mind and soul. In the words of our wartime President—"Physical Fitness, Mental Courage and High Spiritual Ideals Will Win This War."

Let the members of The Medical Society of New Jersey hereby pledge ourselves to the attainment of this high conception of physical, mental, and spiritual health and make it our contribution toward the winning of this war.

#### LEGISLATIVE COMMITTEE

At the request of DR. B. S. POLLAK, Chairman of the Legislative Committee, the Executive Secretary of that committee, DR. F. J. QUIGLEY, read the following report (in abstract):

DR. QUIGLEY: In the report of bills of particular interest to the Society which was presented to the Welfare Committee, September 14, 1941, reference to Assembly Bill No. 484, by Mr. Young (Morris), was omitted because of the uncertainty at that time as to whether further efforts would be made to pass the measure.

This bill provided for the establishment of a bureau of industrial hygiene in the Department of Labor with a deputy commissioner in charge, and for the appointment of certain technical personnel.

In opposing this bill we took the position that while in entire accord with its objectives, the administration of a bureau of industrial hygiene is a medical problem and therefore such a bureau should be headed by a competent physician experienced in industrial medicine; recognizing, of course, that other skills: engineering and chemical, would also need to be employed. The bill was reported out of committee but not otherwise moved.

Shortly before the introduction of this bill (A. 484) the State Department of Health had applied to the United States Public Health Service for certain personnel which would form the nucleus for a bureau of industrial hygiene within the Department of Health, which the Public Health Service was prepared to furnish and for which federal funds were available for salaries. A physician experienced in industrial hygiene, an engineer, and a chemist were assigned to the Department by the Public Health Service and have been functioning since August. The Department of Health is pleased and encouraged by its initial efforts and results. The industries visited have welcomed the surveys and appeared anxious to carry out the recommendations suggested.

Whether a bureau of industrial hygiene should function in the Department of Health or in the Department of Labor is a moot question; and upon it the Society has taken no definite position. In the majority of states where such bureaus have been established they have been placed in the Department of Labor.\*

With the country at war it is to be presumed that the State Legislature is likely to have a

\* DR. CARLISLE stated that according to his survey, 38 states have Bureaux of Industrial Health and that in 36 states this is attached to the Department of Health, in only one state is it part of the Department of Labor, and that in the remaining state the jurisdiction is divided.



shorter session. Most of its labors will be toward the enactment of war and defense legislation. We are inclined to think that the Legislature will not view kindly proposals to enact legislation that is not particularly necessary at this time, and it is our feeling it would be a mistake to introduce legislation of a controversial nature.

In the new Dental Practice Act enacted by the passage of Assembly No. 38, the amendment agreed upon by the Dental Society and our own Society to insure the continued right of physicians to treat diseases of the mouth and to practice oral surgery was inadvertently omitted. The Legislative Committee of the State Dental Society had its counsel draw a bill to amend the Act to provide for the inclusion of the omitted section, and this bill was introduced by Senator Summerill on January 13. It is unlikely there will be any great difficulty passing it.

Assembly Bill No. 167, which would have removed from the Workmen's Compensation Act the arbitrary limit of \$150 for the medical and hospital care of hernia cases, passed the Assembly without opposition, but failed of Senate passage because of the unwillingness of Senator Schroeder (Bergen) to move it. The reintroduction of this measure is recommended, and it is our opinion that it would be preferable to have it introduced in the Senate.

The Chiropody Act, particularly because of the absence of a real definition, needs amendment. Since this is a controversial subject, we recommend that the excellent bill proposed by the Society last year be not introduced at this session unless the chiropodists reintroduce the thoroughly obnoxious bill they presented to the 1941 Legislature.

As usual, at least one chiropractic bill will be introduced at this session. And it is to be expected that replicas of bills to permit individual physicians having substandard educational requirements to take the examination for licensure will likely be introduced. These and any other bills inimical to public health will, of course, be sharply opposed.

We shall continue, as we have in the past, to support measures sponsored by the Department of Health, the Department of Institutions and Agencies and other state agencies which are in the interest of public health.\*

#### PUBLIC RELATIONS

DR. CHARLES ROBBINS, Chairman of the Public Relations Committee, reviewed the activities of the committee's meeting (see page 106 of this *Journal*) and then made the following remarks:

DR. ROBBINS: The intimate coöperation between Organized Medicine and the Federal Government during this war emergency has once more lighted up the patriotism, efficiency and unselfishness of the medical societies. The Government has recognized the contribution of Organized Medicine. Whatever disagreements there may have been between the national administration and medicine have been

dissolved, not only by the need of unity, but by the magnificent assistance which medicine has rendered.

We know this and the Government knows it, but does the public know it? Probably not. The Public Relations Committee, therefore, feels that it has a real function in making the public aware of the incalculable contribution of Organized Medicine to the war effort.

We hope to publicize the fact that the Medical Procurement Division of the Government is securing trained medical men and placing them where they can do the most good; and that it can do this only because the A. M. A. had the foresight to prepare its now famous card index file back in 1940. This, in turn, was made possible because the state medical societies secured the data for the A. M. A. In this enormous task, every individual doctor, every county medical society, and every state medical society played an important rôle. The Woman's Auxiliaries were helpful in activating doctors to answer questionnaires. Without this concerted effort, the procurement of medical officers would have been in a state of inutterable chaos. It is the duty of the Public Relations Committee to underline this service.

Civilian Defense has its most poignant problem in the medical field: namely, the prevention and treatment of air-raid casualties. For this reason, first aid committees and medical assistance of all sorts have been given the Number One position in civilian defense. Here too, the contributions of Organized Medicine are invaluable, and it is our duty to acquaint the public with the rôle of The Medical Society.

To teach first aid to 10 per cent of the civilian population is the laudable goal of the Office of Civilian Defense. This can be achieved only through the sacrifice and coöperation of the doctors. The distribution of the training and the assembling of the doctor-teachers will be best implemented through the assistance of Organized Medicine.

The Public Relations Committee, therefore, will temporarily suspend much of its non-emergency health education work and devote its efforts to these things:

1. Acquainting the public with the indispensable rôle of Organized Medicine in procuring physicians for the armed forces.

2. Making the public aware of The Medical Society's rôle in promoting the health, first aid and medical aspects of civilian defense.

3. Activating doctors to contribute to this effort by means of direct appeals, posters and publicity.

4. We shall discuss with the Medical Preparedness Committee the possibility of placing in every hospital staff room in New Jersey a poster reminding physicians to enroll in the Medical Procurement Division and explaining that no doctor is too old, too disabled or too young to place his name on file for this purpose.

The Public Relations Committee feels its functions should be directed not only toward the public, but also toward all publicity means within the structure of The Medical Society itself.

\*Also see page 105 for minutes of this committee.

### ACTION

The reports of the four subcommittees were individually considered and upon motions duly seconded and carried, all four reports were adopted by the Welfare Committee.

#### STATE BOARD OF MEDICAL EXAMINERS

DR. S. BARBASH, President, and DR. E. HALLINGER, Secretary of the State Board of Medical Examiners, presented a proposal for annual registration of physicians in New Jersey through legislation which the Board recommends be sponsored by The Medical Society.

Dr. Barbash favored annual registration because:

1. It would be a protection to the public against illegal practice by unlicensed practitioners.

2. It would provide a record of all physicians practicing in the state.

3. It would provide a record of deceased physicians whose names could then be taken out of the active records, and thus it would prevent unlicensed physicians from taking over the practice of deceased physicians and operating under the deceased physician's name.

4. It would prevent physicians who cannot obtain a New Jersey license but who are licensed in New York State and reside in New Jersey, from illegally practicing medicine from their homes.

5. It would offer protection from out-of-state physicians, not licensed in New Jersey, from setting up offices at shore and resort cities for the vacation period.

6. It would provide a list of physicians who are non-members of organized medicine, and aid in approaching them for membership.

Twenty states have annual registration. In New Jersey the dentists, pharmacists, midwives, chiroprodists and nurses have annual registration. The Board calculates that the first two years' fee would be \$3.00; after that the fee could be reduced. The \$3.00 fee would enable the Board to gather a small surplus upon which to operate.

Both Dr. Hallinger and Dr. Barbash emphasized the financial necessity of added funds for the State Board if it is to operate efficiently and enforce the provisions of the Medical Practice Act. Funds obtained from fines amount to about half the cost of prosecuting a case. Since the Navy and Army are taking medical graduates without examination for licensure, the income from examination fees will be reduced.

Dr. Barbash stated the State Board of Medical Examiners would appreciate the endorsement of this by The Medical Society of New Jersey.

DR. H. COMANDO and DR. S. SNEDECOR reviewed the objections to annual registration, the foremost being that in the past, at least it was considered another "nuisance" tax.

DR. QUIGLEY briefly supplemented Dr. Barbash's statements from the viewpoint of the Legislative Committee.

DR. FIELD, DR. LEWIS, DR. STOKES and DR. ROBBINS also participated in the discussion.

DR. LEWIS moved that our consideration of annual registration be deferred until the meeting of the House of Delegates in April, and that the columns of our *Journal*<sup>1</sup> be opened to the State Board of Medical Examiners for a presentation of their reasons for favoring annual registration. This motion was seconded by Dr. Burkett and carried.

#### MEDICAL PREPAREDNESS COMMITTEE

In the absence of its Chairman, DR. CHARLES SCHLICHTER, the Committee's Secretary, DR. NORMAN SCOTT presented the following report:

DR. SCOTT: On November 1, 1941, Dr. Schlichter accepted an appointment as Chief of Emergency Medical Service on the Staff of the New Jersey Defense Council, with Dr. Scott as Associate Chief.

Offices of the Medical Division are in the Trenton Armory. Direct contact between our staff office, The Medical Society and the Council is maintained by representation on the Health Committee of the Council.

*Industrial Health:* An Industrial Health Unit assigned to New Jersey by the U. S. Public Health Service, consisting of an industrial physician, chemist, and engineer, is working under the administrative jurisdiction of the New Jersey Health Department. The Unit is surveying the facilities and rendering advice on industrial health in the Defense Plans of New Jersey. It is assisted on a national basis by the facilities of the United States Public Health Service and National Health Institute, on the state level by the laboratories and other facilities of the State Department of Health, and on the local level by local health officers and their facilities.

The Health Committee of the Council has advised that it be placed permanently under the administrative jurisdiction of the State Department of Health. It is a question whether it should remain under the Health Department, be placed under the Labor Department, or arrangements made for joint jurisdiction. The Medical Society will be represented at this conference.

*Municipal Defense Programs* are on a municipal basis, and the Mayor or governing body of the municipality is responsible for proper local organization and operation. Authority for operating the medical phase of the program in each municipality has been delegated to the hospitals and the medical profession; in this way, bringing medical plans under the control of the physician and The Medical Society of New Jersey.

There are seven administrative branches of the State Council. In each branch office, there is a Deputy Chief of Emergency Medical Service to whom is delegated by the Council the duty of organizing and integrating local plans within his branch area. These deputies are: Dr. Cosgrove, Dr.

1. See page 111 this issue.



McKiernan, Dr. Riener, Dr. Herrman, Dr. McMahon, Dr. Decker and Dr. Kilduffe.

Local Chiefs of Emergency Medical Service have been appointed in about 300 of the state's 567 municipalities. These appointments, made by the local councils, are being filled at a satisfactory rate, and it is expected all appointments will be made within a short time.

Local plans, regardless of the size of the community, must be made for each municipality. All plans and all facilities must be on file in the state office for distribution to the coordinating centers of the Council, located at Trenton, Hammonton and Morristown. This is necessary if the plans are to be properly integrated and operated on a state basis should the occasion arise. A file for each municipality is maintained in the medical division of the state office of the Council. These files must be complete before our organization is completed. We urge that all local medical chiefs communicate with their respective deputies for advice and assistance. At a meeting with the Council to be held January 17, we will present a formula by which all local plans will be integrated with other phases of defense on a state-wide basis.

*Red Cross:* A satisfactory agreement with the American Red Cross Chapters has been evolved. Copies of this agreement are available. A survey of the 62 New Jersey Chapters is now under way. Forty-four chapters have already rendered their reports to the Council.

Red Cross Nursing Aid classes are being conducted in 22 hospitals. First Aid classes are in operation in most of the chapters. County Medical Societies are cooperating. We urge that all physicians offer their services as instructors, and that they prepare themselves as instructors by participating in an instructor's course.

Hospitals are cooperating well. Emergency Field Units have been established in most of our general hospitals, in accordance with the provisions of Bulletin No. 1. Arrangements are being made to supply each hospital with one emergency equipment unit when the hospital is properly organized and certified.

A special meeting of the Hospital Association to consider the Defense Program was held on January 15.

*First Aid Squads,* supported by voluntary funds, properly implemented with ambulances, medical equipment, and personnel, are being brought into the program under authority of the State Defense Acts. Special legislative authority sponsored by The Medical Society as formerly anticipated to govern these Squads will not be requested.

We ask for the full-hearted cooperation of every member of the Society, according to policies laid down by the State Council, and as provided by the Defense Laws, in order that the medical phase of the program may be a credit to the profession and The Medical Society of New Jersey.

*Selective Service Boards:* Rapid increase in the size of our armed forces necessitates rapid increases in the number of men to be processed. Estimates at present call for about 1,000 men a day to be examined by the Induction Boards. There are now

about 1300 physicians in New Jersey acting as examining physicians. We urge an immediate increase of examining physicians to meet the new demand, that new selectees be examined in groups and that the examination of single selectees in the private office of the physician be discontinued.

*Induction Boards:* The present personnel of Reserve Officers is unable to meet with demand of Induction Stations carrying a load of nine to twelve hundred daily. Supplementation of Army personnel is considered a responsibility of physicians not called for active duty. On January 9 we were requested to submit the names of 218 additional examiners for the Newark and Camden Boards. We are distributing to you today blanks upon which we ask you to designate the time you may be able to devote to this work, indicating the type of work for which you are qualified. The hours will be from 8 a.m. until the day's quota is processed, usually about 3 p.m. Compensation will be at the rate of pay of Major in the Medical Corps, Regular Army.

*Physical Defects and Rehabilitation:* A representative of this committee was given opportunity to review all reports of physical defects and the present status of the rehabilitation program in the office of the Federal Selective Service System. The national rate of rejection for all causes is about 50 per cent. The majority of defects are dental and visual. Other defects correspond closely to the estimates made in New Jersey by this committee and previously presented to the Welfare Committee.

The rehabilitation program will be administered by the Selective Service System on national, state and local levels. Rehabilitative work will be done by private physicians. Fees paid will be in accordance with the schedule providing payment to private physicians by the Veterans' Administration. Rules and regulations governing this Plan are now being formulated, and will be available about March 1. The average costs of rehabilitation as determined by the committee appointed by the Federal Selective Service from among the membership of the District of Columbia Medical Society is estimated at \$118.67 to cover medical, surgical and dental work, and hospitalization at \$5 per day. Indications are that the initial program will cover only those rejectees with dental and visual defects. We have been requested not to present the plan in detail in its present form because of the many uncertainties involved.

*Procurement and Assignment:* A representative of this committee spent several hours in the Federal office of this new agency. The agency was presented to the physicians of New Jersey by its Executive Secretary at the meeting of the New Jersey Hospital Association on January 15, and later discussed by Dr. Fishbein in Atlantic City on January 16.

It was organized on the advice of the National Medical Committee. Its Board is headed by Dr. Lahey. Its function will be the assignment of all physicians, dentists, and veterinarians to the armed services, Public Health Service, Veterans' Bureau, or any Federal agency requiring the services of physicians. It will be represented by a committee



in each Corps Area. Chairman of the Second Corps Area is Dr. Booth, with Dr. Carrington as a New Jersey member. The Chairman for the State of New Jersey is Dr. Schlichter. County Chairmen or representatives will be appointed. A meeting of state representatives will be held in Washington in February.

The Congress has ruled that all men, including physicians, under 45 will be considered available for military duty; that older physicians will be considered available for assignment among the civilian population. At present the Assignment Service is most interested in men under 36 years of age who express a willingness to volunteer. Dr. Schlichter has asked me to request that all physicians under 36 years of age take immediate steps to obtain a commission in the Army of the United States.

*The Physician's Role:* The name of every physician in the United States is now on punch cards, showing the classifications of each man and dividing the group into three classes according to ages: below 45 years, 45 to 60 years, and over 60 years; and again dividing them according to the type of work for which they are best suited.

Indications are at present that all physicians under 45 should anticipate a call to active duty, and that all physicians over 45 should expect either assignment to non-military duty or very active participation in the selection and induction phases or in programs to provide medical and public health care to the civilian population.

We will be glad to answer questions relative to the functions and organization of this new agency.

Dr. Schlichter has asked me to present his apologies for not being present today, and to express to you the following thought:

"I hope that every member of the Welfare Committee will appreciate the seriousness of the present situation, particularly as it relates to the medical profession, that you will upon return to your County Societies promote the entire support by your Society of the civilian and military programs now being evolved, realizing that the great responsibility being assumed by the profession is our duty as citizens of this great democracy, and in closing to remind you that the Army, the Navy, and all Federal services are placing the affairs of medicine as far as possible in the hands of the civilian medical profession. This is what we of the profession have requested, and this is our opportunity to carry out this policy."

#### ANNUAL MEETING

DR. LEROY A. WILKES, Executive Officer of The Medical Society of New Jersey, outlined the proposed program for the Annual Meeting in Atlantic City in April. A large part of the program will be devoted to war medicine.

#### MEDICAL SERVICE ADMINISTRATION

In the absence of DR. E. W. LANCE, President of its Board of Governors, the following report was presented by DR. NORMAN M.

SCOTT, Medical Director of the Medical Service Administration:

DR. SCOTT: On September 14, the Board of Governors submitted a report to the Welfare Committee which was published on page 535 of the October 1941 *Journal of The Medical Society of New Jersey*. To overcome the difficulties then presented, the following steps have been taken with the approval of the Board of Trustees:

*Joint Administration* with the Hospital Service Plan of New Jersey of Plan 2, providing payment for medical care of hospitalized patients, insofar as the functions of the two organizations parallel one another, has been arranged. An agreement between the two organizations has been approved in substance by the Board of Trustees, and on January 15 was presented to the Commissioner of Banking and Insurance for approval. It will receive final consideration by the Trustees at their meeting on January 25, and prior to signature of the agreement by the officers of the Board of Medical Service Administration. This agreement affects the administration of Plan 2 only.

*Elimination of Income Status:* Income limitations for Plan 2 have been eliminated. This decision was reached after careful consideration at many meetings of the Board and Executive Committee. The type of hospital accommodations occupied by the patient will determine the differential between total fees for services rendered, and part fees as a credit toward the payment for services rendered.

*Subscription Rates* for Plan 2 are as follows: For employed persons, 75 cents per month; that is, \$9000 a year for each thousand persons enrolled. For a family of two persons, the rate is \$2 per month, or \$24,000 a year per thousand families. Three dollars per month per family of over two persons, or \$36,000 per year per thousand families enrolled.

*Enrollment Procedures* will be carried out by the Hospital Service Plan. Initially, emphasis will be placed upon plants with one thousand or more employees. All groups will be approved by Medical Service Administration, and the total number of persons enrolled will be limited according to the number considered safe by the Administration during an experimental year.

*Physicians' Fees* will be on a unit basis. A "Schedule of Benefit Units" has been formulated to cover the most common medical services. It will be further developed as we gain experience. A copy will be filed with the Commissioner of Banking and Insurance, and with the Hospital Plan.

After careful study, including an analysis of 100,000 Hospital Plan cases, a basic value of \$1.50 has been applied to the unit. The current value of the unit will be above or below this estimate, depending upon the relationship between income from subscribers and the amount of services rendered. Fees paid by the Administration will be deemed as payment in full for services rendered patients admitted to wards or rooms containing three or more beds per room. Fees by the Administration will be considered as a credit against physicians' bills if patient occupies accommodations of two or one bed

rooms; the total fee to be arranged as is the usual custom between the patient and the physicians.

All services rendered by physicians will be payable, including medical, surgical, obstetrical, surgical assistants, and anesthetists.

*Patient-Physician Relationships:* All matters pertaining to the relationship of patients and physicians or concerning medical services rendered will be administered entirely by the office of the Administration.

*County Participation:* Since approval by the Trustees at their last meeting, the following county societies have approved the above changes, and agreed to participate: Hudson, Essex, Union, Passaic, Mercer and Burlington. Early effort has been made to present Medical Service Administration to the above counties, because our initial enrollments will be emphasized in these counties.

Cumberland at its special meeting, at which a ballot would not have been official, gave the Administration a vote of confidence, and agreed to vote on the matter at its next regular meeting.

Somerset County at a regular meeting disapproved of Medical Service Administration, and its members will not participate in Plan 2. The Board of Governors regrets that this action was taken without an opportunity to give a full presentation of Medical Service Administration before that Society.

Medical Service Administration is not an organization being promoted by its Board of Governors. It is an agency organized by The Medical Society of New Jersey, controlled by the Society and the physicians of New Jersey. Participation by any County Society is voluntary. It is your organization, operating in the interests of the medical profession, and the answer to the problem presented by the Society to the Voluntary Health Insurance Committee, and later to the Board of Governors. It is your organization, operated for you under policies determined by the Board of Trustees.

*The Farm Plan and Indigent Plans:* The Farm Plan has operated successfully for eight months. It has paid full fees according to the Schedule, and on January 1 the fees for office calls, in which medicine is prescribed, will be increased to \$1.50.

On a basis of what we have learned by its operation, we are now prepared to offer indigent plans to our municipalities. The cost of these plans will be in accordance with prevailing morbidity rates. We feel that while this is a new approach in determining costs in the municipalities, it is a correct one. In principle, it has the approval of the Municipal Aid Administration, and has met with the approval of several municipalities. The Farm Plan has shown us that on a sick rate of 60 to 65 per thousand per month, we can maintain a fee schedule of \$1 in the office and \$2 in the home, at a cost of 19.9 cents per person per month. A plan determined on such a basis interests Freeholders and other governing bodies. If the sick rate in every given period is increased or decreased, the cost will be adjusted. If services other than home or office care are desired, we are prepared to give an estimate of that cost. At the request of the City of Camden, we are now reviewing the experi-

ence of their indigent load for the past three years to determine their sick rates with a view to submitting a plan and its costs for the care of the indigent in Camden. We have been asked to sit in with a committee to make a similar study of the indigent problem in the City of Newark.

The above basic principles of determining plans for the care of the indigent is approved by the Indigent Committee of The Medical Society. At present our work must be considered as entirely preliminary, but offering bright prospects for bringing the care of the indigent under the provisions of plans formulated by and approved by and controlled by the medical profession.

Medical care of the indigent is considered by the Board of Governors as its most important objective. The Board believes that with proper time and support by the medical profession in municipalities, its progress in reaching its objective will be made.

#### ACTION ON PUBLIC HEALTH RESOLUTIONS

*Adult Health Supervision* (page 103, Ex. 1): On motion by Dr. Nichols, duly seconded, the resolution was adopted.

*Venereal Disease* (page 102): On motion by Dr. Nichols, duly seconded, the recommendation was adopted.

*Health and Welfare Conference* (page 103): On recommendation of the Public Health Committee, Dr. Nichols made a motion that this resolution be adopted by the Welfare Committee, and that it be forwarded to the Board of Trustees and Officers of the Society, with our recommendation for early favorable consideration and action. Seconded and adopted.

*Defense Council* (page 103): Dr. Nichols moved the adoption of this resolution and moved that the Secretary send copies to the Governor, Legislative leaders, Defense Council, the State's leading newspapers, and to all interested organizations within the State. Seconded and adopted.

#### X-RAYS IN SOMERSET COUNTY

The Chairman read a letter from the Essex County Medical Society which called attention to a newspaper clipping publicizing the taking of x-rays by the Somerset County Tuberculosis Association for \$1.50 each. On motion duly passed, the Secretary of the Welfare Committee was instructed to refer the matter to the Somerset County Medical Society for investigation.

The Committee rose at 4:30 p. m. Following is the role of attendance at the meeting:

#### ATLANTIC

Dr. Hilton S. Read, Chairman  
Dr. David B. Allman

BERGEN

Dr. Spencer T. Snedecor

BURLINGTON

Dr. Joseph M. Kuder Dr. S. Emlen Stokes

CAMDEN

Dr. Reuben L. Sharp

CUMBERLAND

Dr. Millard F. Sewall Dr. H. Burton Walker

ESSEX

Dr. Harry N. Comando Dr. Charles M. Robbins

GLOUCESTER

Dr. Wendell J. Burkett Dr. Chester I. Ulmer

HUDSON

Dr. J. Lawrence Evans Dr. Berthold S. Pollak

HUNTERDON

Dr. Samuel B. English

MERCER

Dr. D. Leo Haggerty

MIDDLESEX

Dr. Jacob J. Mann Dr. Ralph J. Faulkingham

MONMOUTH

Dr. C. Byron Blaisdell Dr. Stanley Nichols

OCEAN

Dr. J. Edwin Obert

PASSAIC

Dr. Sigurd W. Johnsen

SALEM

Dr. C. Spencer Davison

SOMERSET

Dr. Frank L. Field

SUSSEX

Dr. James H. Spencer

UNION

Dr. Norman W. Burritt Dr. Frederic W. Lathrop  
Dr. Herschel S. Murphy

WARREN

Dr. William H. Varney

OFFICERS

Dr. Thomas K. Lewis, President  
Dr. Elias J. Marsh, President-Elect  
Dr. Samuel Alexander, Trustee  
Dr. Harry R. North, Trustee

STAFF

Dr. LeRoy A. Wilkes, Executive Officer  
Dr. Henry A. Davidson, Editor  
Dr. Norman M. Scott, Executive Assistant  
Dr. Frederic J. Quigley, Legislative Executive Secretary

GUESTS

Dr. Emil Frankel	Dr. Lorrimer Armstrong
Miss Margaret Ashmun	Dr. Robert E. Watkins
Dr. Ellen C. Potter	Dr. Ralph Buchanan
Dr. J. Mallory Carlisle	Dr. William C. Wilentz
Dr. W. G. Guthrie	Dr. Merton Griswold
Dr. E. S. Sherman	Dr. Louis Collins
Dr. Anthony Conty	

ADVISORY

Dr. Samuel Barbash Dr. Earl Hallinger  
Mr. William MacDonald

## SUBCOMMITTEE ON MEDICAL PRACTICE

The Subcommittee met at Trenton, January 18, 1942.

Present were: Dr. Sharp, Chairman; Drs. Zehnder, Johnsen, Carlisle, Ulmer, Barbash, Murphy, Ruoff, and Harryman of the Committee; Dr. Lewis, President; Dr. Wilkes, Executive Officer, and Dr. Griswold of Union County.

### NURSING

DR. C. A. ZEHNDER, Chairman reported that the Office of Civilian Defense is arranging with the Red Cross to give courses in First Aid, Home Nursing and Nurses' Aide work. Under the auspices of the nurses' organization, refresher courses will be given for retired or inactive R.N.'s.

The Course for Voluntary Nurses' Aides is very important. These women will take 80 hours of training and pledge themselves to do whatever is necessary in their own, or in a nearby community

in an emergency, for five years. These women are urgently needed. It is difficult to secure enough women for the course because of home ties and other obligations. This group will be trained in the hospitals by the Red Cross with the coöperation of the hospital. They will be assigned to hospital work.

The Home Nursing Group will be trained to nurse in the homes if graduate nurses are not available.

The Refresher Courses for retired R.N.'s should be given in class rooms of nursing training schools. These class rooms are being used daily. The courses could be given at night but the women who would take the courses object because of home obligations.

We can urge this work through the Woman's Auxiliary. Good work has been done in some places. In others it has lagged. All we can do is make the hospitals and nursing groups available for teaching. It is then up to the Red Cross to utilize them.

### AUXILIARY MEDICAL SERVICES

At a meeting on December 14, 1941, several measures were acted upon. These are reported



by DR. SIGURD JOHNSEN, Chairman, as follows:

1. It was thought inadvisable to change the name of the committee at this time, inasmuch as no better designation had yet been agreed upon.

2. DR. W. J. MARQUIS was appointed to conduct a survey of x-ray facilities available for emergency work in the State. DR. ARTURO CASILLI was asked to report on Clinical Laboratory Unit organization.

3. The Chairman of the New Jersey State Hospital Association Committee, Mr. Lee, was requested to select a representative of his committee to discuss with a member of our committee each of the respective divisions of the work. After these discussions have taken place a joint meeting of the two committees will be held.

4. The question of a Civil Service Examination for the appointment of a physio-therapist at Hope Dell in Passaic County was discussed. This matter has since been clarified by Dr. Wilkes in defining this appointment as that of a technician rather than that of a physio-therapy director.

5. Our Society has now embarked on an insurance plan whereby anyone may purchase complete health insurance on an annual pre-payment basis. Roentgenologists, clinical pathologists, physio-therapists and anesthetists are, as a result of the relationship with the Hospital Service Plan, practically excluded from the benefits of this insurance plan as proposed by the Medical Service Administration of New Jersey. It was therefore deemed pertinent that this Committee again affirm that these activities are part of the practice of medicine and that steps must be taken to safeguard these endeavors to meet with the recently stated resolutions of the American College of Surgeons and the American Medical Association.

The last point was discussed at length by DR. THOMAS K. LEWIS and Dr. Johnsen. Dr. Johnsen accepted Dr. Lewis' addendum, that is to add that this arose "as a result of the relationship with the Hospital Service Plan practically".

#### INDUSTRIAL HEALTH

DR. J. M. CARLISLE, Chairman, reported progress in industrial health and hygiene in New Jersey. Aside from the active assistance to several large industrial organizations, we have also given assistance and advice to labor, official agencies and other groups while working in conjunction with the New Jersey State Department of Health, and with representatives from the National Institute of Health.

(A brief outline of the activities of the Chairman was included in the report and is on file in the Executive Offices.)

Aside from the specific activities of your Committee, we have collaborated in the industrial health services of the Bureau of Industrial Hygiene now functioning in the New Jersey State Department of Health. During the past five months studies have been made of fifty-six plants concerning their med-

ical for first aid set-ups, and their provisions for the prevention and control of industrial illness regardless of cause. Forty-seven investigations were made to detect and study environmental health hazards in industrial establishments in the State. In most of these, detailed reports were prepared and recommendations made, if indicated. At least 36,000 workers were involved in the plants covered; most of the latter, incidentally, have national defense contracts. This work included a survey of all the fur-cutting and rough-felt body hatting factories in the State. On the basis of this survey, a report was made in which it was recommended that action be taken to prohibit the use of mercurial carrot and mercurially carotated fur in these industries. This project was recommended and requested by the Conference of State and Provincial Health Authorities of North America in line with similar activities throughout the country.

In addition to a certain amount of administrative work, consulting services pertaining to the plant worker, environmental, medical and nursing problems were supplied by mail, long distance telephone and personal visits in the office, hospitals and plants.

Laboratory and scientific equipment has been made available through the N. J. State Department of Health and the Division of Industrial Hygiene of the National Institute of Health, Bethesda, Maryland.

Dr. Carlisle reported briefly on the Industrial Health Conference called in Chicago by the A. M. A. on January 12, 1942, at which a report prepared by the representatives of the Council on Foods and Nutrition of the A.M.A. was presented. This concerned: "Vitamin Administration in Industry."

Dr. Carlisle asked Dr. Lewis the present status of nutrition studies in the Medical Society. Dr. Lewis stated that the question had been referred to the Adult Health Supervision Committee and to the Child Health Committee for study. This should be all coördinated through the Medical Preparedness Committee. Dr. Lewis will recommend to Dr. Schlichter that he appoint a subcommittee on nutrition on which committee Dr. Carlisle will represent Industrial Health, together with representatives of Adult Health and Child Health. Dr. Lewis will also suggest to the Council on Nutrition in New Brunswick that one of the subcommittee be appointed to the Council.

Dr. Carlisle announced that on January 26, Governor Edison will hold a conference in relation to the Bureau of Industrial Health with representatives of the Labor and Health Department, the Medical Society and the Industrial Surgeons Association. Undoubtedly there will be official recognition of the Bureau on that date and we will know whether it is to be operated by Labor or Health Department.

Dr. Carlisle asked Dr. Lewis if he would care to avail New Jersey of the services of Dr. Peterson's Survey Committee from the A. M. A. Dr. Carlisle felt such a request to the A. M. A. would bring prompt response.

At Dr. Lewis' suggestion, the Medical Practice Committee agreed that Dr. Carlisle should take this matter up with Dr. Schlichter; the proposal is endorsed in principle by the Medical Practice Committee.

Dr. Carlisle stated that as a result of the work of the Committee on Industrial Health the demand for medical men in industry will rise. Most physicians believe industrial medicine is out of their line; however, industry needs physicians and many of them are fitted for the positions open. Many industries cannot obtain defense contracts because they lack physicians in plants, and not until the physicians understand what industry wants will the demand be met. The maximum hours agreed upon for the worker is 46 hours spread over a six-day week. Above that number, the accident rate begins to rise, especially among females. Dr. Carlisle has prepared an editorial on this subject for the *Journal*.

#### CONTRACT PRACTICE

DR. A. C. RUOFF, Chairman, reported that nothing in the way of contract practice had been referred to the committee since the last meeting. The committee is ready and willing to aid in the program of medical preparedness and again offers to collect data on the available emergency services of life insurance companies, which is felt to be a source of value that has been overlooked. However, nothing will be done until the committee is so requested by Dr. Schlichter.

#### MEDICAL CARE OF THE INDIGENT

DR. H. S. MURPHY, Chairman, reported that he met with Drs. Scott, Lewis and Wilkes to discuss putting in Newark and Camden a plan of Medical Care to the Indigent through the M. S. A. to be paid for with governmental funds. Another meeting is scheduled for today at which we hope to plan to do something more concrete before the end of the year.

#### WORKMEN'S COMPENSATION

DR. W. K. HARRYMAN said that his committee is trying to complete some of the projects started last year. One of our duties is to review legislative bills having to do with Workmen's Compensation. This year we want to reintroduce the "hernia bill" which was held up last year due to politics. The Legislative

Committee will be asked to reintroduce the bill.

The A. M. A. Workmen's Compensation Committee asked Dr. Harryman for several copies of the pamphlet on Workmen's Compensation which appeared on page 453 of the September *Journal of The Medical Society of New Jersey*. These copies were to be sent to other states with a suggestion that they do the same. This is the first State Society which has done this piece of work.

#### PHARMACEUTICAL PROBLEMS

DR. CHESTER ULMER, Chairman, described his committee's activities in the publication and distribution of the New Jersey Formulary, fourth edition. A copy was mailed to every member of the Society and a reserve supply of copies is on hand in the Executive Offices to take care of new members for perhaps a year or two. Copies of the Formulary have also been sent to internes in New Jersey Hospitals and to hospital pharmacies.

Chief purpose of the Formulary is to discourage physicians from prescribing overpriced brand-controlled proprietary medicines. It is gratifying to note that this compend of formulas has become popular with many physicians in the State and reports would indicate that good use is being made of it.

The Committee is willing and anxious to assume any duties that may be assigned to us during this war period.

Dr. Sharp suggested that Dr. Ulmer write an article for the *Journal* recommending prescribing as nearly as possible from the N. J. F.; this would result in less confusion about the shortage of drugs. Dr. Ulmer accepted the suggestion and stated he would submit such an article to the Editor.

#### ANNUAL REPORTS

Dr. Sharp requested all advisory committee chairmen to attend the next meeting of the subcommittee and be prepared with written recommendations for presentation. All recommendations presented will be later considered by the Welfare Committee, which will refer them to the House of Delegates for further consideration and action.

Adjourned at 12:15 p. m.

REUBEN L. SHARP, M.D., Chairman,  
Subcommittee on Medical Practice.

## SUBCOMMITTEE ON PUBLIC HEALTH

A meeting of Public Health Committee was held January 18, 1942, in Trenton. Present were: Dr. Stanley Nichols, Chairman; Dr. Frederic Lathrop, Dr. A. E. Jaffin, Dr. Arthur W. Bingham, Dr. Elbert S. Sherman, Dr. C. Byron Blaisdell, Dr. Harvey Ewing, Dr. Millard F. Sewall, Dr. William H. Varney, Dr. Emil Frankel, Dr. Wilson G. Guthrie, Dr. Ellen Potter, Dr. Walter Alexander, Dr. Marsh, Mr. William McDonald, and Miss Margaret Ashmun. Dr. Lewis was present for a short time.

### TRAFFIC ACCIDENTS COMMITTEE

DR. MILLARD F. SEWALL, Chairman, announced that at the recommendation of the Traffic Accidents Committee there will be in the February issue of the *Journal*, a questionnaire,<sup>3</sup> for each member to complete and return to the Society, on types of pathologic conditions which would cause a driver's license to be withdrawn, temporarily or permanently. The purpose of the questionnaire is to collect data to be used as a basis for advice to the Commissioner of Motor Vehicles. Individual cases will not be reported as such, but rather as a mass estimate on which the Motor Vehicle Department may form an opinion as to the advisability of regulatory action.

### ADULT HEALTH SUPERVISION

DR. WILLIAM H. VARNEY, Chairman, announced that the government has already set up a rehabilitation program at government expense for rejected draftees who can be made fit for military service. There is still a large group who need rehabilitation for civilian occupation. In this connection a resolution (exhibit 1, page 103) was presented. Dr. Varney moved its adoption; it was seconded and unanimously carried.

### PREVENTION AND CONTROL OF HEART DISEASE

See Exhibit 2, page 103.

### TUBERCULOSIS CONTROL

DR. A. E. JAFFIN, Chairman, reported that additional x-ray equipment for the Camden and Newark Induction Boards has been made available through members of the committee. An effort is being made to aid schools which are making tuberculosis surveys in determining a more uniform and better classification of diagnoses. Arrangements have been made through the Tuberculosis League for distributing an approved statement of "Revised Diagnostic

Classifications" to all Departments of Education and those engaged in the work of case finding. The question of the responsibility of reporting cases of tuberculosis came up at the last meeting of this Advisory Committee. The law does not specifically state who is responsible. It was agreed to defer the question until an opinion was obtained from the Department of Health and from the Attorney General.

Under the present policy of the Department of Health, cases incorrectly reported as tuberculosis are not removed from the files unless the original report is withdrawn by the physician. There is no law forbidding withdrawal of the original incorrect diagnosis, but such action would definitely stigmatize the physician. Some physicians therefore refuse to change their original diagnoses. The matter was referred to a committee of the Department of Health for further study.

### MATERNAL WELFARE

See Exhibit 3, page 104.

### CONSERVATION OF VISION

See Exhibit 4, page 104.

### VENEREAL DISEASE CONTROL

DR. C. B. BLAISDELL, Chairman, said that serious financial difficulties have developed in the Bureau of Venereal Disease Control because of increased expenses and expanding work and decreased appropriations. This Advisory Committee feels that something should be done to support the good program of this bureau, and the following recommendation is offered. This was approved by the Council of the Essex County Medical Society:

"That this committee recommends that the Council go on record as favoring a special state appropriation of at least \$50,000 for venereal disease control for this year, and that the Council ask The Medical Society of New Jersey to consider this matter and recommend favorable action on it."

Dr. Blaisdell moved that the Public Health Committee approve the recommendation thus offered. Seconded by Dr. Lathrop and unanimously carried.

### REPORTABILITY OF CANCER

It was regularly moved, seconded and carried that the Public Health Committee approve in principle the proposed bill to make cancer a reportable disease in New Jersey. This approval was given by a mail vote in September of 1941 and the motion was made as a matter of official record. The bill is outlined on page

3. See page 108 this issue.



544 of the October *Journal of The Medical Society of New Jersey*.

#### NEGRO HEALTH

A. written report, submitted by DR. WALTER G. ALEXANDER, will be found on page 105 as Exhibit 5.

#### PLEDGE OF AID

Dr. Nichols presented the following resolution:

*Be It Resolved*, That The Medical Society of New Jersey pledges to the Governor and Legislature, the Defense Council and citizens of this State, its united support of all wartime measures for the improvement and maintenance of better public and private health for all of our own New Jersey citizens, and hereby volunteers, collectively and individually, for all-out service in all wartime health plans.

It was regularly moved, seconded and carried that this resolution be adopted and that the Secretary of the Society send copies to the Governor, Legislative Leaders, Defense Council, the State's leading newspapers, and to all interested organizations within the State.

#### GOVERNOR'S HEALTH CONFERENCE

Dr. Nichols introduced the following resolution:

*Whereas*, The United States of America, on December 7th, 1941, entered the world-wide war for human liberty, and

*Whereas*, This act makes it essential that our medical profession immediately examine our various increased responsibilities for the public and private health of the citizens of New Jersey during this national crisis, and

*Whereas*, It is of the utmost importance that our health professions be united and coördinated in our joint effort to develop and maintain the highest possible degree of physical, mental, and spiritual health among our people for the winning of this war;

*Therefore, Be It Resolved*, That The Medical Society of New Jersey call upon our Governor to reconvene the Governor's Health and Welfare Conference of 1939 (which was completely representative of the health professions of the State, all private and public health and welfare agencies, and all State Departments) under the leadership of its outstanding Chairman, President Robert J. Clothier of Rutgers University, and request the Governor to direct the Conference to make an immediate and continuing study of all wartime health needs of New Jersey citizens, and make definite recommendations at suitable intervals to the Governor and Legislature as to specific measures to be taken to increase and maintain a high degree of physical fitness, mental courage, and spiritual ideals among New Jersey's men, women and children—these being

all essential for the achievement of victory in this war, and

*Be It Further Resolved*, That copies of this resolution be sent by our Executive Officer to all Health and Welfare Agencies in New Jersey, with a request that they pass similar resolutions as soon as possible, and send them to the Governor and legislative leaders of this State.

#### AMBULANCE FOR PREMATURES

A letter had been received from Dr. Chester Brown, Chairman of the Advisory Committee on Child Health, requesting approval by the Committee on Public Health, of a resolution suggesting a "premature" ambulance to be located in some hospital by the State Department of Health.

Dr. Lathrop moved that the Public Health Committee approve the proposal. It was seconded and unanimously carried.

L. A. WILKES, M.D.,  
Executive Officer.

#### EXHIBIT 1

*Whereas*, A study of the rejections made by induction boards in New Jersey, from November 25, 1940, to July 8, 1941, for medical causes shows 4,250 rejections, 54 per cent of whom could be rehabilitated for useful civilian occupation, or possible later army services;

*Be It Resolved*, That The Medical Society of New Jersey, through its component county societies, endorse the rehabilitation program of the Federal Government by urging rejectees who cannot be made fit for military service to seek proper medical care either from private physicians or through clinics, to make them better fitted for the strenuous duties of civilian defense work. It is urged that each Society provide a social service follow-up on these cases.

#### EXHIBIT 2

The Advisory Committee on the Prevention and Control of Heart Disease met on December 17, 1941. DR. H. M. EWING, Chairman, presided. The Committee decided upon the following three-point program:

1. That the Committee would offer its services as an Advisory Committee to the Governor of the State of New Jersey or such agencies as he might designate. The Committee would propose to function in an advisory capacity regarding the rehabilitation of men rejected by the State Selective Service Board because of heart disease or in other matters pertaining to the subject of heart disease in its relation to the present emergency. In this connection it was proposed to communicate with all the heart clinics in the state with the hope of using the heads of such clinics as "keymen" in an elaboration of a more detailed program to be developed after conference with state authorities.

A letter was sent to Governor Edison on December 19, 1941, advising him of the plan. The Governor referred this matter to Colonel E. N. Bloomer, Acting State Director for Selective Service, who replied on January 6, 1942, stating that no definite directive had been received from National Headquarters for Selective Service regarding rehabilitation. He stated further that he was "cognizant and keenly appreciative of the splendid coöperation of the members of The Medical Society of New Jersey. We will certainly avail ourselves of the assistance of your Committee upon the institution of the rehabilitation program."

Governor Edison also referred our letter to Dr. J. Lynn Mahaffey, Director of Health of New Jersey, who has requested that the Chairman of this Committee meet with him to discuss this subject. Arrangements have been made for this conference.

Contact has been made with 57 hospitals asking whether they operate a cardiac clinic and whether they would be willing to take part in our program. To date, 30 returns have been received, 28 stating their willingness to coöperate.

2. The second point in our projected program is the study of a plan submitted to the Crippled Children's Division of the United States Children's Bureau. We shall consider seeking funds for the commencement of a New Jersey program.

3. A study of the heart disease problem in the State of New Jersey to be followed by concrete recommendations looking toward prevention and control of heart disease.

The execution of these last two items may have to be deferred until after the war, and our energies concentrated upon the first point in this program.

#### EXHIBIT 3

The Advisory Committee on Maternal Welfare is anxious to coöperate in meeting all public health and medical care needs of our people. DR. ARTHUR W. BINGHAM, Chairman, reports two objectives:

1. In case of disaster, how to care for maternity patients who have been obliged to move from neighboring localities.

2. What to do with maternity patients in a hospital when the space they occupy is needed for the injured.

The Chairmen of the County Committees on Maternal Welfare have been asked to survey their counties in regard to space available for maternity patients. This has been done in most localities by the local Defense Committees or the Red Cross with little reference to maternity cases.

The Chairman of the Advisory Committee on Maternal Welfare strongly recommends the following. Where there is a crowded local hospital a delivery service should be retained with a few hospital beds. The patient would then receive adequate delivery care and after three days be moved to an obstetric unit set up for

convalescent care in a floor of a hotel or any other available space. A few patients might be sent to their homes if they could get nursing care.

This plan has four objectives.

1. Adequate delivery care to maintain the high standard we aim for in order to avoid complications which cause prolonged convalescence or possibly a mortality. It will not help in national defense to lose a mother of several small children.

2. To conserve nursing care by moving the patients to convalescent obstetric units three days after delivery where hospital facilities are limited.

3. To save duplication of equipment by caring for patients in delivery suites in hospitals followed by post partum care in obstetric units or homes.

4. To conserve physicians for emergency work by caring for maternity patients in groups.

Whatever plan is carried out must be for the benefit of future mothers and babies and must in no way lower the standard of maternal welfare.

#### EXHIBIT 4

DR. E. S. SHERMAN, Chairman of the Advisory Committee on Conservation of Vision, reports as follows:

In a circular entitled "Suggestions to Committees on Medical Defense Program", your Advisory Committee on Conservation of Vision was asked to study school data on visual defects.

While the time has been too short to make a detailed statewide investigation, the members of the Committee, who are all in the active practice of ophthalmology in various parts of the state, believe that the charges that appear in print from time to time alleging serious neglect of school children's eyes are greatly exaggerated. Such statements are often made by people who have no exact knowledge of the conditions. Some of them emanate from individuals who are interested in the sale of glasses. It has been stated that in several of the counties there is no eye clinic. This is true but it does not necessarily follow that eyes are being neglected.

Our Committee expects to investigate the need for further facilities for the examination and treatment of eyes in rural districts and if the need is apparent, may recommend the formation of a part-time traveling clinic with a paid ophthalmologist.

Optometrists are constantly trying to infiltrate the schools as eye examiners and it has been necessary to remind certain local Boards of Education that it is illegal to permit physical examinations in the schools by any one but a physician or by some one under his supervision.

Any intelligent person can be taught in a short time to conduct screening tests that discover cases of defective vision. Such cases should be further investigated by an ophthalmologist. No one without the aid of a cycloplegic can adequately examine the eyes of little children.

Continued and increasing efforts should be made to educate the public concerning the value of pre-school examinations of children's eyes. This is the time and usually the only time when amblyopia from strabismus can be corrected. This type of amblyopia is a common cause of rejections by draft boards and of applicants for employment.

Three days ago the Chairman of this Advisory Committee received a letter from the Secretary of the Committee on Health, Welfare and Recreation of the State Defense Council, stating that at a meeting of his Committee held on January 2, 1942, Dr. Earl H. Ridgeway presented a report of the Committee on Optometric Preparedness of the Public Health and Welfare Bureau of the New Jersey Optometric Association in connection with civilian defense. He said that he was instructed to communicate with our Advisory Committee and request us to confer with the New Jersey Optometric Association with the object of reaching a working basis to make use of the suggestions contained in the report. Our Committee will of course comply with this request. Concerning visual defects as a cause of army rejections, I have been unable to obtain any exact local data. The Surgeon General of the Army announced that during March and April, 1941, 36,800 out of 243,955 men, or 11.3 per cent, were rejected because of eye defects. I am told by a member of a local induction board that most of the rejections were because of myopia and other refractive errors. There are many other types of defects that are a cause of rejection but their nature is well known to all ophthalmologists. Unfortunately in many cases after the individual has attained the draft age nothing much can be done about them.

#### EXHIBIT 5

DR. WALTER G. ALEXANDER reports as follows:

Despite knowledge of conditions, the Negro health problem is always serious. Until recently nothing was done in a direct way. After becoming a member of the State Board of Health,

I sponsored a program of health activities among Negroes. It was put into operation about two years ago.

It is planned to have the coöperation of all health agencies in the State, official and voluntary; the U. S. Public Health Service, medical and dental organizations and the Department of Health. Records were obtained in each county regarding health status of the Negro.

To begin this work the colored physicians of the State were called together in order to get a better understanding of their own responsibility. It has had a very stimulating effect on the group. Refresher courses in tuberculosis and venereal disease have been given to these physicians—also courses in heart disease, cancer and child welfare. Colored physicians are now working in various venereal disease clinics throughout the state.

Health units have been set up in various localities, on a yearly basis. A speakers' bureau of 16 physicians is available for addressing public meetings.

During the last Negro Health Week 81 meetings were held—they were well attended. The purpose is to give to the Negro masses, many of whom are ignorant and illiterate, a knowledge of hygiene and the prevention of disease.

In addition to the educational project, a program of case finding has been developed—3,500 persons have been x-rayed for tuberculous conditions.

A Nurses' Institute has been conducted and now colored nurses are in clinics in Camden, Trenton, Elizabeth and several other cities.

Operation has been on a rather limited budget, but there is now an appropriation from the State and an additional budget from the Society Security funds.

This year the program will lay emphasis on syphilis.

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### SUBCOMMITTEE ON LEGISLATION

A meeting of the Subcommittee on Legislation was held January 18, 1942, in Trenton, with the Chairman, DR. B. S. POLLAK, presiding. Members present were: Drs. Pollak, Watkins, Burkett, Wilentz, Kuder; Quigley, Executive Secretary, and Alexander, Consultant. Visitors present were: Drs. Jacob Mann; William K. Harryman, Chairman of the Workmen's Compensation Committee; Dr. Samuel Barbash, President of the State Board of Medical Examiners; and Dr. Henry A. Davidson, Editor of *The Journal*.

The tentative report to the Welfare Committee was read and discussed. This will be found on page 93 of this *Journal*.

Attention was directed to Assembly Bill No. 167. This bill removes from the Workmen's Compensation Act the arbitrary limit of \$150 for the medical and hospital care of hernia cases.

Following a discussion of this bill, Dr. Kuder moved that this committee recommend its introduction in the Senate. Seconded by Dr. Burkett. Unanimously carried.



## ANNUAL REGISTRATION

Dr. Burkett reported on a meeting held in Trenton in December, attended by representatives from the State Board of Medical Examiners, the Osteopathic Legislative Committee, the Chiropractic Legislative Committee and Drs. Quigley and Burkett of the State Society's Legislative Committee. The State Board of Medical Examiners have not had sufficient funds to make proper investigations of illegal practice in the State because their income has been drastically reduced by the diminished number of licenses by reciprocity, the citizenship clause in the new Act, and the inability of many applicants to take examinations because of the war emergency. They feel that annual registration would be a means of increasing their income, as well as providing an accurate check as to all physicians and other licentiates practicing in the State. The Chiropractic representative was of the impression that some of the rights of the chiropractors might be taken away under such an Act. The Assistant Attorney General, who had prepared a tentative bill, explained that annual registration would not deprive licensed chiropractors of any of their present rights. It was finally agreed that the attorney of the N. J. Chiropractic Society would meet with the Assistant

Attorney General to discuss the bill. Representatives of all the groups were to report the meeting to their respective societies.

The Executive Secretary stated that if such a bill were introduced into the Legislature, it would be necessary that it have the support of every county society in the State. About fifteen years ago the State Society went on record as sanctioning registration, but shortly before the time intended to introduce the enabling bill, the Essex County Medical Society announced opposition to it. This County Society contended that it added another nuisance tax and that no great advantage would accrue from annual registration.

The Committee was of the opinion that this matter should be brought before the Welfare Committee for decision.

## CHIROPODY ACT

Dr. Kuder moved that the bill proposed by The Medical Society of New Jersey last year be not introduced this year unless the chiroprodists reintroduce their bad bill of last year. Seconded by Dr. Watkins. Unanimously passed.

FREDERIC J. QUIGLEY,  
Executive Secretary,  
Subcommittee on Legislation.

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SUBCOMMITTEE ON PUBLIC RELATIONS

The Subcommittee on Public Relations met at Trenton on January 18, 1942. The Chairman, DR. CHARLES M. ROBBINS, presided.

DR. HENRY A. DAVIDSON, Secretary of the Committee, reported that the newspaper response to the Kiwanis speaking project had been highly gratifying. Releases were sent from the Public Relations office to all newspapers in New Jersey.

DR. ROBBINS reviewed the rôle of the Public Relations Committee in the promotion of the Fourth Annual Fall Clinical Conference in Elizabeth on December 3, 1941. The function of winning attendance for the Conference from all parts of the state had been largely entrusted to the Committee. Posters were placed in all hospitals in New Jersey. Announcements of the Conference were read at all county medical meetings in October and November. Special space was given in the *Journal*. Proof of the effectiveness of this large scale intra-Society program was seen in the attendance records. The Conference of December, 1941, was the largest (in terms of registration) of any clinical conference ever held by The Society.

DR. DAVIDSON reported on the active co-operation given by the Woman's Auxiliary, particularly in publicizing the radio program of the American Medical Association. The Committee has been called on frequently by the Auxiliary to provide speakers and speech scripts, and to date all requests have been fully met.

A financial report was read, showing that with only three months left before the Annual Meeting, the Committee had spent less than half of its budgetary allotment.

Methods of publicizing the Annual Meeting were discussed, and the Committee voted to urge the Annual Meeting Committee to provide the Public Relations Office with advance scripts of all talks so that they might be adequately publicized.

A letter from DR. ABRAHAM JAFFIN was read which suggested that attention be given to the efforts of Assemblyman Browne to scuttle the Medical Practice Act. This was referred to the Subcommittee on Legislation.

The problem of publicizing the important rôle of Organized Medicine in the war effort

was reviewed. It was felt that if the Trustees and Medical Preparedness Committee approved, the Public Relations Office could acquaint the community with the fact that the efficient procurement of physicians for military and civilian services was being expedited through the activities of medical societies.

Dr. Robbins' formal report to the Welfare

Committee was read and approved. (See page 94 of this *Journal*.)

A resolution of thanks was voted to the Woman's Auxiliary for their active promotion of publicity for the radio project of the American Medical Association.

HENRY A. DAVIDSON, M.D.,  
Secretary.

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## AUXILIARY MEDICAL SERVICES COMMITTEE

The Committee on Auxiliary Medical Services met on December 14, 1941, at the office of the Chairman, Dr. Sigurd Johnsen, Passaic, N. J. In addition to the Chairman, Drs. Casilli, Yaguda, Marquis and Read (Jr.) were present.

The question of changing the name of the Auxiliary Medical Services Committee to one more appropriate was discussed. The discussion brought out the fact that there was no name sufficiently simple and all-embracing to include the four divisions represented by this committee, namely: clinical pathology, roentgenology, physiotherapy and anesthesia. Further, in view of the fact that the committee has been in continuous existence for a number of years, it was thought inadvisable to change this name at the present time.

One objective of the committee for this year was to correlate our work with that of the preparedness program. The Chairman appointed Dr. Marquis to conduct a survey of the x-ray facilities available for emergency work in the state. Dr. Casilli was appointed to report on a clinical laboratory unit set-up.

Coöperation with the New Jersey Hospital Association Committee was discussed. This Committee consists of Mr. Lee, Chairman; Mr. I. E. Behrman, Mr. Frank B. Gail, Mr. John R. Howard, Jr., and Rev. John G. Martin. It was decided to appoint one representa-

tive of our Committee representing each field of our endeavors to meet with one member of the Hospital Committee to hold preliminary discussions. After these discussions have taken place, a joint meeting of the two committees will be held.

A letter was sent to Dr. Wilkes in reply to a request asking the attitude of this Committee on the civil service examination for a physiotherapist at Hope Dell in Passaic County. The Committee felt that it would be advisable to determine the status of physiotherapy in the light of the new Medical Practice Act, and Dr. Wilkes was requested to determine whether physiotherapy was a part of the medical practice as defined by the new Act.

The Medical Society of New Jersey has now embarked on an insurance plan whereby anyone may purchase complete health insurance on a pre-payment basis. Roentgenologists, clinical pathologists, physiotherapists and anesthesiologists are excluded from the benefits of this insurance plan as proposed by the Medical Service Administration of New Jersey. It was deemed pertinent that this Committee again affirm that these are part of the practice of medicine and that steps must be taken to safeguard these endeavors to meet with the recent resolution of both the American College of Surgeons and the American Medical Association.

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## MEDICAL PREPAREDNESS COMMITTEE SECRETARY AND MEDICAL SERVICE ADMINISTRATION MOVE

The Medical Service Administration of New Jersey announces that it has moved its offices from Trenton to Newark, and all communications should be addressed to Dr. Norman M. Scott, Medical Director, Medical Service Ad-

ministration, 31 Clinton Street, Newark.

Dr. Scott will also function as Secretary of the Committee on Medical Preparedness from the Newark address.

ANNUAL REPORTS TO THE HOUSE OF DELEGATES

All annual reports must be in the Executive Offices by March 1. This includes all the committees and officers of the Society.

Galley proofs of the reports will be sent to

the authors and corrected proofs must be returned to the Editorial Office by March 20. If proofs are not returned by that date the report will be published as in the galley proof.

PEDIATRIC CONVENTION

The annual convention of Region I of the American Academy of Pediatrics will meet in Philadelphia during the first three days of April, 1942.

On Wednesday morning, clinics will be offered in several hospitals. On Wednesday afternoon papers will be presented on various aspects of haematology in pediatrics. On Wednesday evening there will be a seminar on pediatrics and national defense.

A conference on prematurity on Thursday morning will be of interest to obstetricians and pediatricians. Thursday at noon a number of special luncheon meetings will be held, grouped according to functional interests such as child health, contact infection, school health, etc. On Thursday afternoon a panel discussion on air-

borne infections will present new material of special interest to all practitioners. Three round tables are also available that afternoon: one on orthopedic pediatrics, one on reading difficulties and one on pediatric dermatology. A social evening topped by a banquet will feature the Thursday evening program.

Friday morning offers a panel discussion on poliomyelitis with a full review of Sister Kenny's new relaxation treatment. Also scheduled for Friday morning is a talk on pediatric endocrinology and a presentation on habit training for children. The convention terminates at noon on Good Friday.

A more detailed program may be secured from Dr. J. M. Lyon, 40 Llanfair Road, Ardmore, Pennsylvania.

QUESTIONNAIRE ON CAR-DRIVING PATIENTS

The Commissioner of Motor Vehicles has requested our Committee on Traffic Accidents to advise him as to the kinds of disorders which would justify revoking or suspending a driver's license. This questionnaire is part of an effort to meet that request. It does not involve the matter of breaching any patient's confidence, since individual names are not wanted. The Department wishes a mass estimate, an idea of the incidence of disabling illness among automobile drivers.

It is therefore requested that every physician fill in the following and send it to: Committee on Traffic Accidents, The Medical Society of New Jersey, 143 East State Street, Trenton.

HOW MANY PATIENTS UNDER THE FOLLOWING HEADINGS DO YOUR RECORDS OR ESTIMATES SHOW AS HAVING A CONDITION IN WHICH YOU WOULD ADVISE THEM NOT TO DRIVE A MOTOR VEHICLE?

Hypertension .....	Heart Disease .....
Epilepsy .....	Visual Defects* ...
Alcoholism .....	Hearing Defects ...
Drug Addiction ....	Mental Deficiency..

What other conditions, in your opinion, might justify the revocation or suspension of a driver's license?

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It is not necessary to sign your name. Do not give names of any patients. The information will be tabulated, and submitted as a series of gross totals. Reports of individual doctors will not be submitted separately. Do not list all cases of hypertension, heart disease, etc., but only those in which you feel there is a motor-vehicle hazard.

\* Please include cases of color blindness under "visual defects".



## WITH NEW JERSEY MEDICAL AUTHORS

From time to time *The Journal* will publish in this space the names of members of the Society who have contributed recent articles to the medical literature. Due to the method of indexing scientific material, it is impossible to prepare an absolutely complete list, since there is no one place in which medical articles are listed by residence or author. It is therefore requested that any New Jersey physician who publishes an article outside the state notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

The following list covers December, 1941:

- ABEL, A. R. (East Orange)  
Sulfaguanidin; absorption, excretion and therapy. *J. M. Soc. New Jersey* 38:629-633, Dec. 1941.
- BARBANO, A. J. (New Brunswick)  
Multiple shell wounds; case report. *Am. J. Surg.* 54:731-732, Dec. 1941.
- BELING, C. A. (Newark)  
Sulfaguanidin; absorption, excretion and therapy. *J. M. Soc. New Jersey* 38:629-633, Dec. 1941.
- BINGHAM, A. W. (East Orange)  
Statistics on puerperal hemorrhage as a cause of maternal mortality in New Jersey. *Maternal Welfare* article No. 65. *J. M. Soc. New Jersey* 38:649-651, Dec. 1941.
- BURNHAM, LYMAN (Englewood)  
Rôle of isoimmunization in the pathogenesis of erythroblastosis fetalis. *Am. J. Obst. & Gynec.* 42:925-937, Dec. 1941.
- CHESLEY, LEON C., and ELIZABETH R. (Jersey City)  
Extracellular water in late pregnancy and its relation to the development of toxemia. *Am. J. Obst. & Gynec.* 42:976-983, Dec. 1941.
- DAVIDSON, HAROLD S. (Atlantic City)  
Treatment of septic thrombophlebitis with heparin and sulfathiazole. *J. M. Soc. New Jersey* 38:642-644, Dec. 1941.
- GAMON, ROBERT S. (Camden)  
Technical approach to the surgical abdomen. *J. M. Soc. New Jersey* 38:626-628, Dec. 1941.
- GOLDBERG, H. C. (Plainfield)  
Combined epilation needle and forceps handle. *Arch. Dermat. & Syph.* 44:1104-1105, Dec. 1941.
- GOLDMAN, LESTER M. (Newark)  
Effect of pregnancy-urine hormone and vitamin B-6 on the blood and bone-marrow pictures in primary erythroblastic anemia (Cooley). *J. Clin. Endocrinology* 1:945-948, Dec. 1941.
- GOLDSTEIN, HYMAN I. (Camden)  
Cancer of the stomach in children and young adults. *Rev. Gastroenterol.* 8:450-458, Nov.-Dec. 1941.
- KATZIN, E. M. (Newark)  
Rôle of isoimmunization in the pathogenesis of erythroblastosis fetalis. *Am. J. Obst. & Gynec.* 42:925-937, Dec. 1941.
- KILBORN, MELVILLE G. (West Orange)  
Preliminary clinical report on a new carbon dioxide absorbent — Baralyme. *Anesthesiology* 2:621-627, Nov. 1941.
- LEVINE, PHILIP (Newark)  
Rôle of isoimmunization in the pathogenesis of erythroblastosis fetalis. *Am. J. Obst. & Gynec.* 42:925-937, Dec. 1941.  
Rôle of isoimmunization in transfusion accidents in the pathogenesis of erythroblastosis fetalis. *Am. J. Clin. Path.* 11:898-901, Dec. 1941.
- LOSADA, CAMELLA A. (Summit)  
Malarial disease uncovered by auto-hemo-fever therapy after thirty-five years. *J. M. Soc. New Jersey* 38:647-648, Dec. 1941.
- MAHAFFEY, J. LYNN (Haddonfield)  
Poliomyelitis in New Jersey. *J. M. Soc. New Jersey* 38:645-646, Dec. 1941.
- MALAVAZOS, ANTONIO (Newark)  
Effect of pregnancy-urine hormone and vitamin B-6 on the blood and bone-marrow pictures in primary erythroblastic anemia (Cooley). *J. Clin. Endocrinology* 1:945-948, Dec. 1941.
- MATHIS, JOHN H. (Atlantic City)  
Clinical study of two unusual types of renal and ureteral disease. *J. Urol.* 46:1079-1099, Dec. 1941.
- PROUT, THOMAS P. (Summit)  
Malarial disease uncovered by auto-hemo-fever therapy after thirty-five years. *J. M. Soc. New Jersey* 38:647-648, Dec. 1941.
- ROGERS, LAWRENCE H. (Trenton)  
An unorthodox but effective treatment of scarlatina. *J. M. Soc. New Jersey* 38:634-635, Dec. 1941.
- ROTH, J. J. (Newark)  
What are decibels? A painless analysis. *J. M. Soc. New Jersey* 38:639-641, Dec. 1941.
- SHIVERS, CHARLES DET. (Atlantic City)  
Clinical study of two unusual types of renal and ureteral disease. *J. Urol.* 46:1079-1099, Dec. 1941.

## HEART COMMITTEE AND THE DEFENSE PROGRAM

The Advisory Committee on Prevention and Control of Heart Disease adopted a resolution on December 17, 1941, offering to Governor Edison its services as an advisory agency on the rehabilitation of men rejected by Selective

Service boards because of heart disease. The committee consists of Dr. Harvey Ewing, its Chairman, and Drs. Stanley Nichols, Jerome G. Kaufman, Thomas J. White, Allen Rieck, Edwin Murray and LeRoy W. Black.

## AN OUTLINE HISTORY OF OUR SOCIETY

In the January 1942 issue of the *Proceedings of the New Jersey Historical Society*, appears an outline history of The Medical Society of New Jersey to 1903. This carefully documented and scholarly article has been written by ELIAS J. MARSH, M.D., President-Elect of The Medical Society of New Jersey. It describes in readable and vivid style the forma-

tion of the Society and its development during the eighteenth and nineteenth centuries. Dr. Marsh has succeeded in setting this against the rich background of the times in which the Society and its members moved, so that it is more than a study of one organization: it is a kaleidoscopic picture of the State of New Jersey during 150 active years.

## IMPROVEMENT IN SCHOOL MEDICAL SERVICE

### VI

The unique opportunity of pediatricians in State Committees, in medical schools and as community leaders demands some familiarity with problems of organization and administration of school health work as well as recognition of those trends that seem desirable to physicians. An excellent discussion of these problems has been presented by John W. Stuebaker, U. S. Commissioner of Education, and Fred Moore, M.D., late Director, Department of Health, Public Schools, Des Moines, Iowa. They clearly set forth the educational function of all that is done for the health of the child. Commissioner Stuebaker interprets organization principles and Dr. Moore gives an excellent explanation of the multiple relationships which need to be established in the adequate development of a school health program that is educational. They both insist upon only one form of organization and repeatedly assert the superiority of education department control until the reader must expect that unnecessary difficulties, duplications, and inefficiencies overwhelm all programs that are not under the complete control of the school authorities. This bulletin is based upon the experience of Dr. Moore in Des Moines and shows clearly how through organized effort the school can contribute to the teaching of "children and parents to be resourceful, self-reliant, and intelligent in meeting their own health problems". While the "purely service level" of a school health program has often been seen under health department control, the emphasis in Des Moines upon health education was

unique and only a few other programs under education department control gave such an emphasis. There is undoubtedly a strong tendency for medically trained leaders to prefer to have the emphasis in the schools upon education rather than service. The important thing is to get strong medical leadership such as was given by Dr. Moore. Too often the educators employ physicians only for examinations and not for administration and leadership, so that some of the best medical direction has been given by health departments.

"Health Appraisal of the School-Age Child, Minimum Standards" by the American Academy of Pediatrics Committee on Coöperation with Non-Medical Groups and the motion picture "When Bobby Goes to School" are recommended as valuable for promotion of sound medical advice.

"School Health Services" by W. Frank Walker, Dr. P. H., and Carolina R. Randolph is of interest because of the kind of activities in Tennessee that are described as typical of many programs both urban and rural. It is interesting to note that many of the conclusions and the recommendations of the study are in line with our recommendations although the program described is characteristic of what we have criticized. There is a notable absence, however, of recognition that the private physician might make the examinations of some of the children although for periodic dental examinations the private or clinic dentist is recommended.

## ANNUAL REPORT OF HEALTH DEPARTMENT

The Department of Health of the State of New Jersey has just released its 63rd annual report. A limited supply of this 400-page book is available to doctors on request directed to Dr. J. Lynn Mahaffey at the State House in Trenton. The report covers in every detail the distribution of disease and death throughout

the State, and it is an invaluable reference work for physicians interested in epidemiology, pediatrics and public health. Details of marriages, births, deaths, accidents, suicides and the like are all given, as well as a number of interesting text articles on the sanitary, engineering and nutritional problems involved.

## ANNUAL REGISTRATION OF PHYSICIANS

By EARL S. HALLINGER, M.D., F.A.C.S.

Secretary of the State Board of Medical Examiners of New Jersey, Trenton, N. J.

Following the suggestion made by the President of The Medical Society of New Jersey, Dr. Thomas K. Lewis, we want to present to the membership of our Society facts and data pertaining to the necessity for annual registration.

The New Jersey State Board of Medical Examiners was created to administer the Medical Practice Act, which was instituted primarily to protect the public from the wiles of individuals not legally qualified to practice the healing art in our State.

Many changes have occurred since the original Medical Practice Act became a law, and during these years, criteria have been established which have resulted in the creation of added responsibilities and functions pertaining to the administration of our Act, so that the machinery of the present day is in marked contrast with that set up in former years.

While the Act has been amended from time to time to meet the needs of our time with particular reference to increasing the standards for licensure, no consideration has ever been given to the method of securing funds for the adequate and proper administration of our Medical Practice Act. This neglect naturally has established a *status quo ante* and unless some measure is undertaken to secure funds, the State Board of Medical Examiners will ultimately cease to exist.

The Board has, by the publication of several articles in the *Journal*,<sup>1</sup> attempted to inform the profession at large on the many functions of this body which are so vital to the interest of every man or woman who legally practices medicine or surgery in our State. It, therefore, devolves upon us to see that the administration of this organization be continued.

Annual registration is necessary for the following reasons:

1. Once an applicant is licensed by the Board, all contact with him is lost, unless he is registered annually.

2. Many physicians are practicing without a license in our State. Knowledge of their identity is unavailable except through fortuitous circumstances. Many of these unlicensed individuals are graduates of unrecognized schools, and in this class may be those who were graduated from foreign schools who are

not eligible for licensure due to the requirements set up by the Medical Practice Act.

3. Many licensed physicians are not members of any State or County Medical Society and, therefore, are beyond the control of organized medicine. This frequently includes groups who set up so-called "diagnostic clinics" and are simply practicing "racket medicine".

4. When a physician dies, unless he is a member of his State Society, no knowledge of his death is available. This gives an unlicensed person an opportunity to use this deceased physician's office, equipment and even his diploma. This is not a fantasy but a condition that frequently is uncovered in our investigations.

5. It is to the economic advantage of every ethical physician to register with the Board so that the status of every qualified person is thus known. This knowledge will then enable the Board to institute proceedings to remove from our State all unqualified individuals, thus resulting in a financial benefit to all the registered and qualified licentiates in New Jersey. An average income of, say, \$2000 a year, secured by unqualified or illegal practitioners, is after all, just so much money taken from the pockets of all legally licensed physicians.

6. We have many applications from refugee physicians who are not able to meet our requirements. What becomes of them? Where do they practice? What is to stop them from opening an office in any locality they may select?

7. We are constantly coming across cases of individuals who have been practicing anywhere from two to eight years without a license because the licensed physicians in the immediate vicinity were not curious enough to learn the status of their neighbors, having simply assumed that because a physician's sign was outside the door he was, therefore, a licensed practitioner.

8. The number of physicians applying for examination or endorsement is less due to the war conditions as many physicians have been and will be called into the service of their country.

9. Every person who participates in the field of medicine should be registered, including masseurs, physio-therapists, hydrotherapists and electro-therapists. Standardization of schools and courses should be established for

1. See Jan. 1941 issue, page 42; Feb. 1941 issue, page 97; March, page 146; May, page 263; August, page 421.



this group of practitioners in order that they be licensed to practice in their limited field. At present, there is no control over these people.

10. It is essential that the registered pharmacists throughout the State be supplied with a list of the legally licensed physicians of New Jersey in order to protect themselves from unlicensed physicians.

11. Annual registration is of particular importance due to the stress of the times. It is likely that there will be more unlicensed practitioners in the State than ever before. To prosecute these individuals means that the cost of investigating them will be increased. Con-

sider the present number of unlicensed individuals and add to them the numbers of others who may enter; the cost of investigation in prosecuting these individuals is tremendous. For the protection of the public at large, as well as for the protection of legally licensed physicians in the State, it is imperative that these unlicensed individuals be uncovered and, if possible, prosecuted.

Our finances are down to the vanishing point, and unless new funds are received or made available immediately the Board will have to close its doors. This state of affairs, which is desperate, is the final reason why annual registration should be immediately enacted. We have no alternative.

28 West State Street

## PNEUMONIA SERUM AVAILABLE

The Department of Health announces that pneumonia serum is available gratis at the following stations. The numbers following the name of each hospital indicate the type available.

### *Atlantic County*

Atlantic City Hospital, Atlantic City—1 2 3 4 5 6 7 8 11 14 19.

Atlantic Shores Hospital, Somers Point—1 2 3 7 8.

### *Bergen County*

Bergen Pines Hospital, Oradell—1 2 3 4 5 6 7 8 11 14 19.

Hackensack Board of Health, Hackensack—1 2 3 5 7 8.

Englewood Board of Health, Englewood—1 2 3.

North Arlington Board of Health, North Arlington—1 2 3.

### *Burlington County*

Burlington County Hospital, Mount Holly—1 2 3 4 5 7 8.

### *Camden County*

Camden Board of Health, Municipal Hospital, Camden—1 2 3 4 5 6 7 8 11 14 19.

### *Cumberland County*

Newcomb Hospital, Vineland—1 2 3 7 8.

### *Essex County*

Newark Board of Health, Newark—1 2 3 4 5 6 7 8 11 14 19 23.

East Orange Board of Health, East Orange—1 2 3.

Montclair Board of Health, Montclair—1 2 3.

Nutley Board of Health, Nutley—1 2 3.

### *Gloucester County*

Underwood Hospital, Woodbury—1 2 3.

State District Health Office, 13½ S. Broadway, Pitman—1 2 3 7 8.

### *Hudson County*

Jersey City Health Department, City Hall, Jersey City—1 2 3 4 5 6 7 8 11 14 19.

Hudson County Laboratory, 768 Bergen Avenue, Jersey City—1 2 3 5 7 8.

West Hudson Hospital, Kearny—1 2 3 7 8.

### *Mercer County*

State Department of Health, State House, Trenton\*—1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33.

### *Middlesex County*

St. Peter's Hospital, New Brunswick—1 2 3 5 7 8.

Perth Amboy Board of Health, Perth Amboy—1 2 3.

### *Monmouth County*

Long Branch Board of Health, Long Branch—1 2 3 5 7 8.

Asbury Park Board of Health, Asbury Park—1 2 3.

State District Health Office, Court House, Freehold—1 2 3.

### *Morris County*

Morristown Board of Health, Morristown—1 2 3 4 5 6 7 8 11 14 19.

State District Health Office, 16 W. Blackwell Street, Dover—1 2 3 5 7 8.

### *Ocean County*

Paul Kimball Hospital, Lakewood—1 2 3.

### *Passaic County*

Passaic Board of Health, Passaic—1 2 3.

Paterson Board of Health, Paterson—1 2 3 5 7 8.

### *Somerset County*

Somerset Hospital, Somerville—1 2 3.

### *Sussex County*

Newton Hospital, Newton—1 2 3 5 7 8.

Franklin Hospital, Franklin—1 2 3.

### *Union County*

Elizabeth Board of Health, Elizabeth—1 2 3 5 7 8.

Plainfield Board of Health, Plainfield—1 2 3.

Summit Board of Health, Summit—1 2 3.

### *Warren County*

Warren Hospital, Phillipsburg—1 2 3 5 7 8.

\* Note:—Type 6 same as Type 26.

Type 15 same as Type 30.

## • THE BULLETIN BOARD •

A special Lincoln's Birthday program is planned by the Essex County Medical Society for the evening of February 12. Dr. Elias J. Marsh, President-Elect of The Medical Society of New Jersey, will discuss the "State Administrative Program". Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, will analyze the current trend toward organized medical services. Col. Charles H. Schlichter, Chief of Emergency Medical Service of the New Jersey Defense Council, will present the status of New Jersey doctors as observed by the Medical Preparedness Committee. The meeting opens at 9:00 p. m. at the Academy of Medicine, 91 Lincoln Park, Newark. All physicians are invited to attend.

For the March meeting the Essex County Medical Society announces a talk on recent advances in neurology by the Director of the Department of Neurology of the New York Hospital, Dr. O. S. Lowsley. This meeting will be on March 12.

Dr. James Alexander Miller, Professor of Medicine, Columbia University, will open a conference on diseases of the chest, to be held at the Orange Memorial Hospital on Friday evening, February 27, at 8:30 p. m. The hospital is located at 188 South Essex Avenue, Orange. All physicians are welcome to attend this seminar, which is held under the auspices of the Lung Committee of the Essex County Medical Society.

The Academy of Medicine of Northern New Jersey announces the following programs for February:

Thursday, February 19—8:45 p. m. "Clinical Allergy", Richard A. Kern, M.D., Professor, Clinical Medicine, Medical and Graduate Schools, University of Pennsylvania.

Friday, February 27—4:30 p. m. One hour of colored movies. 1. "Nephropexy for Pronounced Nephroptosis with Kinking of Ureter." 2. "Perineal Prostatectomy: Enucleation of Benign Adenomatous Lobes; Sutures of Vesical Neck to Close Prostatic Wound", Hugh H. Young, M.D., Baltimore. "Transplantation of the Ureters into the Rectosigmoid and Cystectomy for Malignant Tumor of the Bladder". William E. Lower, M.D., Cleveland.

Major Clarence W. Way, Secretary of the Cape May County Medical Society, is now the Commanding Officer of the Station Hospital, Fort Tilden, New York.

An exceptionally interesting meeting has been planned by the Fifth Councilor District of The Medical Society of New Jersey for Friday evening, March 13, at 7:00 p. m. Dr. Harry Subin, President of the Atlantic County Medical Society, will welcome the guests, and Dr. Chester I. Ulmer, Councilor for the Fifth District, will deliver some opening remarks. The principal speaker will be Dr. William Harvey Perkins, Dean of the Jefferson Medical College, who will talk on "Untapped Resources in Preventive Practice". This meeting will be held at the Northfield Country Club, Northfield, New Jersey, which is in Atlantic County on the Shore Road between Pleasantville and Linwood, off Route 9. Dinner tickets at \$1.25 each may be secured from Dr. Harold Davidson, 101 South Indiana Avenue, Atlantic City.

The Philadelphia meeting of the American Academy of Pediatrics for April 1, 2 and 3, 1942, is announced on page 108 of this *Journal*.

The Union County Medical Society at its January meeting voted to buy four thousand dollars worth of United States Defense Bonds.

A small supply of a modern doctor's book-keeping system known as "Hill's Income and Expense Record", is available for free distribution. Physicians should write on their office letterhead to Editorial Department, Medical Economics, Rutherford, N. J., and so long as the supply lasts, a copy of the book and forms will be sent gratis to each applicant.

Mount Sinai Hospital, New York, offers graduate courses in medical statistics, bacteriology, cardiology, gynecology, ophthalmology, pathology, neurology, pediatrics and radiology. These courses are given in coöperation with Columbia University and applications should be directed to the Secretary for Medical Instruction, Mount Sinai Hospital, 1 East 100th Street, New York City.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

The Atlantic County Medical Society was honored by the presence of Dr. MORRIS FISHBEIN, Editor of the Journal of the American Medical Association, as guest speaker at its meeting January 16. His topic was "The Work of Medicine in the National Emergency". Dr. Fishbein predicted that if the war lasts two more years every doctor in the United States who is physically fit and under the age of 45 years will be on duty with the American Army or Navy. He explained this statement in the following way. There are 186,000 doctors in the country today. Of this number 58,667 are not qualified for service because they are over 55 years of age. This leaves 120,000 doctors, of whom only one-half could qualify for commissions by passing the physical examination. There are, therefore, 60,000 doctors under 55 years of age and physically fit. Half of this group are essential for public health work, teaching and war industries and there would be left only about 30,000 doctors under 45 and fit, and all of these will be needed in the army or navy if the number called into service reaches six million men. Dr. Fishbein outlined the problem which American physicians have been working out so that the medical profession and not the government will continue to efficiently control the part played by physicians and dentists in the war, and thereby prevent state medicine. The American Medical Association has the support of President Roosevelt who has approved the new Procurement and Assignment Service Plan for all physicians, dentists and veterinarians.

The scientific program of the evening dealt with "Effective Methods in the Treatment and Prevention of Sinusitis". The speaker was Dr. MARVIN FISHER JONES, Surgeon Director of Otolaryngology, Manhattan Eye, Ear and Throat Hospital. He emphasized the progress made in recent years both in methods of accurate diagnosis in selecting cases for operation and also in better treatment both operatively and by the new sulfanilamide compounds.

After a short business session, Dr. HARRY SUBIN adjourned the meeting. There was the largest attendance this year.

### BERGEN COUNTY

Samuel C. Bump, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held at Holy Name Hospital, Teaneck, New Jersey, on January 13. The meeting was called to order by Vice-President, Dr. HENRY D'AGOSTIN.

Applications for membership:

For Junior Membership: Dr. John J. Daly of Teaneck, N. J.

From Junior to Regular Membership: Dr. Dorothy D. Vann of Englewood, N. J.

For Regular Membership by transfer from N. Y. County Medical Society: Dr. Julius A. Klosterman of Hackensack, N. J.

Elections to membership:

To Junior Membership: Dr. Peter J. Pizzi of Garfield, N. J.

From Junior to Regular Membership: Dr. Joseph Catania of Garfield, N. J.; Dr. Frank J. Hirsch of Wallington, N. J.; Dr. Frank J. Schaberg of New Milford, N. J.; Dr. Irving A. Schultz of Warren Point, N. J.

After a few introductory remarks stating the qualifications of Dr. Samuel Alexander as candidate for the Second Vice-Presidency of The Medical Society of New Jersey, Dr. Snedecor moved that:

1. Bergen County Medical Society endorse Dr. Alexander for nomination as Second Vice-President of The Medical Society of New Jersey at the next Annual Meeting.

2. That the delegates be instructed to work for and vote for Dr. Samuel Alexander for that office.

3. The Secretary and all nominating delegates of the other County Societies be notified of this action.

This was seconded by Dr. Corn, and passed by the Society.

The proposed amendments to the By-Laws, which were read in December, were again read and favorably voted upon. Dr. Knowles made motion to accept the changes and Dr. Tether seconded the motion, which was passed.

Following are the additions to the By-Laws:

Article I, Section 2. Associate Member. (Proposed addition.) "Associate Membership shall be limited to a period of not more than twelve months."

Article III, Section 2. Election of Delegates to State Convention. (Proposed addition to present section.) "This list shall be presented at the regular meeting in February. At this time the President shall entertain nominations from the floor. Elections shall be held at the March meeting."

Article III, Section 3. Member of Nominating Committee of Medical Society of New Jersey. (Proposed amended section.) "One of the elected Delegates shall be selected as member of the Nominating Committee of The Medical Society of New Jersey. This nomination and election shall follow the same procedure and shall take place at the same time as the nomination and election of Delegates and Alternates. The term of this office shall be one year.

"A candidate Delegate may be nominated to this office, but must be elected as Delegate to be eligible for election."

Dr. ZACHARIAH BERCOVITZ, Physician in Charge, Parasitology Service, Department of Health, City of New York, spoke on "Diagnosis and Treatment of Disorders of Intestines". Cardinal symptoms were discussed—bloody diarrhea, often found in amoebic and bacillary dysentery, carcinoma, lympho-granuloma and colitis. Amoebic dysentery is common, onset usually insidious, diagnosis not always easy. He stressed importance of bedside stool examinations under microscope and importance of distinguishing trophozooids from other cells. The speaker illustrated his remarks on diagnosis



with colored slides. Treatment of amoebic dysentery was discussed and emetin hydrochloride declared the drug of choice. Treatment of bacillary dysentery is best accomplished with sulphonal guanidine. Sodium or magnesium sulphate is also suitable. In treating lympho-granuloma of rectum Frei-antigen, although expensive was satisfactory. Chemo-therapy with sulphonilamids may be used. Questions were asked and answered.

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular monthly meeting of the *Burlington County Medical Society* was held on January 8, 1942, in Moorestown, N. J.

PRESIDENT DEAN LE FAVOR welcomed Dr. Betancourt of Camden County; Dr. Alan Hemphill of the Burlington County Hospital; and Drs. Diverty, Wood and Nelson of Gloucester County.

The guest speaker was DR. JOHN A. KOLMER, Professor of Clinical Medicine of Temple University. His topic was "The Sulfonamides". Dr. Kolmer called the discovery of the sulfonamide group the greatest contribution to chemotherapy so far in medical history, even greater than arsphenamin. He listed the six recognized sulfonamide drugs: sulfanilamide, sulfapyridine, sulfathiazole, sulfadiazine, sulfaguanadine and neo-protosil. Dr. Kolmer then described the use of each.

DR. HOWARD M. HEBBLE, Moorestown, was unanimously elected to the County Society.

### ESSEX COUNTY

Paul Hosp, M.D., Reporter

The regular meeting of the *Essex County Medical Society* was held jointly with the Academy of Medicine of Northern New Jersey on December 18, 1941. The meeting was called to order by DR. EDWARD W. SPRAGUE, President of the Academy. He reported on the election of members to the Academy, and then turned over the meeting to DR. FRANCIS WEBER, President of the Essex County Medical Society.

Minutes of the last Council meeting were read and approved. Speaker of the evening, WILLIAM H. PERKINS, M.D., Dean of the Jefferson Medical College, a classmate of Dr. Weber's, was introduced by him. Dr. Perkins discussed "Medicine's Inheritance of World War II".

He said it was hard to prophesy about medicine in the future. We must be open-minded when we talk upon social subjects. The last world war showed that we needed better health among the people. Since then there has been a steady trend towards improvement. Years ago, donations to charity were the privilege of a few. Today we have a community chest and all contribute to health and community welfare. Social control has been a great help in preventing the spread of diseases like tuberculosis, diphtheria and syphilis, etc. They can, however, go just "so far". The medical practitioner is the only one to solve this in his private practice. In his personal contact with individuals, as a doctor and as a citizen he must advise them.

The meeting was now turned over to Dr. Sprague, who agreed that "everything in medicine revolves about the individual doctor. We are indeed fortunate that we have among us a leader, a teacher of physicians." He introduced DR. HARRISON S. MARTLAND, Chief Medical Examiner of Essex County, who demonstrated by new Kodachrome slides, pathologic specimens of interest to physicians and surgeons.

The auditorium was filled to capacity, and it was felt that this joint meeting had been a big success.

The following physicians were elected to membership in the Essex County Medical Society:

Active—Ulysses M. Frank, Newark.

Associate—Vincent J. Giardina, Newark; William L. Gruber, Newark; Henry Wujciak, Newark.

### CHEST CONFERENCE

The chest conference held at St. Michael's Hospital, Newark, on November 27 was a marked success. The subject presented by the Lung Committee of the Essex County Medical Society was "Chest Diseases in Children". DR. BELA SCHICK, the guest speaker, made comments on each case as it was presented. Others taking part were DRs. I. L. APPELBAUM, NATHAN ZVAIFLER, GEORGE MAGGIO and F. P. CARRIGAN.

DR. HARROLD MURRAY acted as Chairman.

The meeting was a huge success not only in interest shown by those in charge, but also by the attendance, which numbered 150.

### GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

On Thursday, January 15, 1942, the *Gloucester County Medical Society* held its regular monthly meeting at the Woodbury Country Club. DR. F. G. WANDALL, the President, was in charge of the meeting.

DR. WILLIAM PEDRICK made the announcement that the government procurement and assignment service would register all men between the ages of 21 and 44. However, at present there is a surplus of physicians both in the Army and the Navy. He also said that if a doctor has not signed the procurement service blank, he will not obtain his commission for several weeks. New questionnaires are to be sent out to each member in the near future. Six doctors of the Society have recently volunteered for the draft board examinations and Red Cross instructors. It was decided in a recent meeting that the draft boards examine the draftees according to the wishes of each individual draft board.

DR. WILLIAM T. LEMMON, Assistant Professor of Surgery at Jefferson Medical College, spoke on "Acute Abdominal Emergencies—Their Diagnosis and Treatment". He presented colored motion pictures to illustrate his subject. He stressed the fact that before any abdominal emergency, if at all possible, the following should be done: (1) X-ray of chest. (2) Flat plate of abdomen. (3) Electrocardiogram. (4) Liver function. (5) Complete blood count. In all cases of acute hemorrhage into the peritoneum, a high blood count is present.

**MERCER COUNTY**

A. D. Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met in Trenton on January 14, 1942, President Cox presiding. Minutes of the preceding meeting were read and approved. President Cox requested Dr. Hirschfeld to introduce the guest speaker, Dr. JOSEPH HUGHES, Psychiatrist of the Institute at the University of Pennsylvania.

Dr. Hughes gave an interesting account of the early studies of cerebral physiology, reciting the several methods employed in the gradual development of the present electroencephalogram.

The speaker described the use of electrical appliances, making an analogy to the development of electrocardiography. The rhythm measured by the electroencephalogram was characterized as the "pulse of the brain". Many diagrammatic slides were shown, all of which Dr. Hughes explained in an instructive manner, following his discourse with answers to several questions propounded by his interested large audience.

Dr. Hughes was accorded an enthusiastic vote of appreciation.

The President then called upon DR. McCULLOUGH for a report on the Civilian Defense program. Dr. McCullough gave a very satisfactory analysis of the progress being made in this direction.

DR. WILLIAM CARROLL reported that an organization meeting had been held by the allied professions, and that committees were now at work.

A communication from DR. BELFORD of Princeton, reporting on the progress in that community relative to instruction in first aid work was discussed.

The special bulletin sent out from the Executive Offices, relative to the several important factors that tend to make a Society meeting interesting and instructive, was mentioned by the Secretary.

A communication from DR. CHARLES SCHLICHTER, appealing for Medical Examiners to assist in the Induction Stations, listing the number of specially qualified physicians, was discussed.

The proposed amendment to the State Constitution and By-Laws, to make the President of the Society an ex-officio member of the Judicial Council, was read in compliance with Article XII.

The Treasurer again urged the members to pay their dues and requested the service men, or any other member, to forward information relative to date of induction into the service.

**MIDDLESEX COUNTY**

Cyril Hutner, M.D., Reporter

The annual dinner meeting of the *Middlesex County Medical Society* was held in New Brunswick on December 17, 1941, with ninety members attending. DR. R. J. FAULKINGHAM, President, presided.

DR. BARTH M. HOWLEY of Highland Park, an associate member, was elected to full membership.

On motion made by DR. SHERMAN a resolution was passed "that members with the Armed Forces of the United States have their dues suspended for the duration of the war".

The following list of members in service was read: Major Frederick S. Taber, Major Carlyle

Morris, Capt. W. A. Balough, Capt. G. R. Gessner, 1st Lt. A. J. Barbano, 1st Lt. George Miller, 1st Lt. B. Friendenthal, 1st Lt. Stanley A. Gadek, 1st Lt. William Rubin, 1st Lt. Howard E. Dieker, 1st Lt. Percy L. Smith.

DR. ROWLAND, reporting for the Nominating Committee, recommended the following officers. They were elected for 1942:

DR. MATTHEW F. URBANSKI, President

DR. JOSEPH H. KLER, Vice-President

DR. C. HOWARD ROTHFUSS, Secretary

DR. GEORGE J. KOHUT, Treasurer

DR. CYRIL I. HUTNER, Reporter

DR. B. F. SLOBODIEN, Delegate to Nominating Committee

DR. J. F. MCGOVERN, Alternate to Nominating Committee.

The following were elected as Delegates and Alternates to the House of Delegates of The Medical Society of New Jersey:

Delegates: DR. R. J. FAULKINGHAM of New Brunswick, DR. J. F. WEBER of South Amboy, DR. JOSEPH GUTOWSKI of Perth Amboy and DR. H. W. HAYWOOD of New Brunswick.

Alternates: DR. P. S. AVERY of New Brunswick, DR. A. X. URBANSKI of Perth Amboy, DR. JOSEPH MARK of Woodbridge and DR. F. M. HOMMAN of New Brunswick.

Guest speaker of the evening was Mr. MELVIN WHITELEATHER, Foreign Affairs Correspondent of the Philadelphia Evening *Bulletin*. Mr. Whiteleather, who is news commentator for radio station KYW, has just returned to the United States after a long stay in Europe. He gave a stimulating talk on "The World Today".

"The secret of Hitler's strength," he said, "lies in his fanatical belief in himself and the weakness of the other powers."

The hatred of the German individual by all the peoples of Europe is tremendous, and when the Hitler group succumbs, as Mr. Whiteleather predicts, "the life of a German outside of Germany will not be worth two cents".

DR. Faulkingham thanked the Society for the confidence and trust placed in him, and asked the members who served on committees for their cooperation and support.

DR. Urbanski thanked the Society for the honor conferred upon him and said: "The 'theme' for our meetings in the year 1942 will be Medical Defense. All our programs will relate to this subject. The Middlesex County Medical Society will give its fullest support and council to the various Civilian Defense Councils, Red Cross and any other recognized agencies working in this field."

**MONMOUTH COUNTY**

Murray Woronoff, M.D., Reporter

Defense was the keynote of the meeting of the *Monmouth County Medical Society* held December 17, 1941, at the Monmouth Memorial Hospital.

The meeting was called to order by DR. B. W. MOFFAT, President of the Monmouth County Medical Society. He spoke briefly of the special purpose of the meeting—to make plans for the organization of medical defense in Monmouth County. DR. WIL-



LIAM HERRMAN has been appointed Deputy Chief, Emergency Medical Services for the Monmouth District by the New Jersey Chief of Emergency Medical Services. Dr. Herrman has also been asked to serve as defense head of Monmouth Memorial and Fitkin hospitals, and of the County Red Cross.

Dr. Herrman explained that the emergency has arisen with such speed that it is necessary for the hospitals and doctors to be ready at a moment's notice to cooperate with the rest of the defense authorities. There are 51 municipalities in the county and each has its own defense council. In addition, firemen, police, and first aid squads in each of these communities have formulated plans for an emergency. Under the plan offered by Dr. Herrman, these agencies would be integrated into one organization.

The local authorities will be asked to assign certain public buildings that can be used as field hospitals; these would include churches, schools and halls. Precautions for doctors who have to go out in the midst of a black-out were explained. Blue paper over the headlights of cars and special insignia are included in these measures.

Dr. Herrman's plan calls for four base hospitals, three subsidiary base hospitals, four roving field hospitals, twelve ambulance stations, four or more Red Cross supply depots for emergency supplies. Doctors will be assigned to definite stations. In all, 106 physicians will be utilized in the various base hospitals and first aid stations. It is also planned to use those county osteopaths who have full licenses to practice medicine but no M.D. degree.

After his presentation of this organization, Dr. Herrman introduced several speakers. The first of these was MR. ALFRED BEADLESTON of Shrewsbury, District Representative of the State Defense Council.

#### STATE DEFENSE COUNCIL

Mr. Beadleston explained what the state council is planning and how that plan is to operate. Monmouth County is a part of the district which also covers Ocean, Atlantic and Cape May Counties, and which is under the head of DR. R. KILDUFFE of Atlantic City. The Medical Division of the State Council is headed by Drs. Schlichter and Scott, to whom the Monmouth County Medical Society organization for defense will be offered for approval. Mr. Beadleston spoke of the efforts of the State Police to coordinate ambulances and first aid squads. Every doctor will have helpers at the scene of his work and every assistance possible will be given to him.

#### RED CROSS AND NURSES

Dr. Herrman then introduced Miss EVELYN T. WALKER, as a representative of the Red Cross and the M. C. O. S. S. Miss Walker outlined the plans of the Red Cross to cooperate with the other county agencies in the matter of defense. Supply depots will be set up in strategic locations and dispatch riders and motor transport workers will be assigned to the field hospitals, first aid stations and base hospitals.

#### FIRST AID

Following Miss Walker's talk, the meeting was addressed by CORPORAL BROOKS of the State Police. Corporal Brooks is a recognized authority on first aid. He emphasized the importance of forgetting sectional differences. In this emergency we must all work together. Corporal Brooks promised full cooperation of the State Police and the Red Cross stressed the fact that all possible assistance will be given to the doctors who are volunteering their services.

DR. H. B. SLOCUM was called upon to speak as Chief of Staff of the Monmouth Memorial Hospital and expressed his approval of the Society's choice of Dr. Herrman as Defense Representative.

DR. O. K. PARRY, as the Society's Defense Counsellor on surgical supplies, then spoke on the contents of the emergency kit which, it is recommended, all physicians carry. "With the contents of this kit, it should be possible for a physician to give emergency treatment to any casualty which might come his way." Doctors are urged to keep these bags separate from their every-day bags. Contents of the kit are based on the bags carried by the Bellevue Hospital ambulance surgeons.

MR. O. R. AUER, Director of the Monmouth Memorial Hospital, told the Society of the work of the Preparedness Committee of the New Jersey Hospital Association.

#### DISCUSSION

Discussion was opened by DR. EDWARD GLAZER, who reviewed the kinds of anesthesia best suited for field hospitals and first aid stations. Dr. Glazer recommended using either a can of ether or a Yankauer mask and ether cone. He did not believe that gas machines were necessary.

DR. O. K. PARRY supplemented his previous remarks by pointing out that there had been purposely omitted from the list of kit contents all instruments and medications that doctors ordinarily carry in their every-day bags. The emergency kit was an addition to, not a replacement of, the every-day bag.

A motion was then passed placing the Society on record as approving Dr. Herrman's plan for the medical defense of Monmouth County. The chair asked that all members of the Medical Society who wished to donate their blood for plasma should stand in their places. Seventy-one responded. DR. C. A. PONS said that with the present shortage of equipment he would rather type the doctors and use them for blood donors in the case of an emergency.

DR. C. B. BLAISDELL asked for information concerning cooperation between the various agencies. He was answered by Corporal Brooks, who stated that in every emergency when a doctor is summoned, the police, first aid squads or any other assistants on hand, are there to help the doctor in every way. He gives the orders and they carry them out. There should be no conflict whatsoever.

DR. D. F. FEATHERSTON introduced the head of the Fort Monmouth Medical Corps, COLONEL PROTZMAN, who told how volunteers for blood plasma had been secured in Englewood. A personal letter, explaining the situation and asking for support, was sent



to everyone in the district served by the Englewood Hospital old enough to qualify. The response was tremendous—40,000 cc. of blood were secured last Sunday alone. Colonel Protzman also stated that in the Army whole blood is used. Every recruit is typed at the time of his induction and when a transfusion is necessary, the medical authorities simply send for a soldier of the correct blood type. The boys get \$25.00 for each transfusion, more than their month's pay.

Also present from Fort Monmouth was MAJOR BYK of the Medical Corps, who stated that the Army was only too glad to keep out of the Civilian Defense authorities' way.

### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

WILLIAM GOLDRING, M.D., Associate Professor of Medicine, New York University Medical College; Associate Visiting Physician, Bellevue Hospital, New York, was the guest speaker for the third lecture in our Post-Graduate Course in Medicine, held at Greystone Park, Thursday evening, January 15, 1942, PRESIDENT D. W. TELLER, M.D., presiding.

It was announced that a series of four lectures for the benefit of physicians who are to teach the Red Cross First Aid Courses would be held at All Souls Hospital beginning January 16, 1942, at 5 p. m.

An appeal was made for physicians to assist in the establishment of a blood bank at the Morristown High School, February 6, 1942, from 2-7 p. m.

Twenty-six doctors have enrolled for a series of lectures under the auspices of the Maternal Welfare Committee under DR. I. F. FROST, Chairman, the first meeting to be held at the Morristown Memorial Hospital, January 29, 1942, when DR. ARTHUR W. BINGHAM of East Orange will speak.

Dr. Goldring's subject was "Recent Advances in the Treatment of Nephritis and Hypertension", with lantern slide illustrations. He particularly reminded us of the great spontaneous variability of blood pressure in various individuals, and warned of the necessity for proving that a kidney has no function, before attempting surgical removal.

It was indicated that the results of sympathectomy and omentopexy have not been impressive, and that the ischemic theory of hypertension has not been proved. As to the use of sodium sulphocyanate, it was pointed out that the systolic pressure falls, and not the diastolic, and with the drug discontinued, the hypertension returns. In addition, the drug is toxic and may produce hallucinations, muscular fatigue, nausea and vomiting, dermatitis, motor aphasia and even death.

The use of extracts in hypertension is an interesting hypothesis, in which there are two schools: (1) Extract from normal kidney, producing an antipressor substance, i. e., an anti-ischemic principle, which Dr. Goldring thinks does not work. (2) Has to do with metabolic substances, the Amines, and that there is too little ferment, or oxygen, to assist in complete protein digestion.

The use of pyrogenic insulin was also not recommended; even though the blood pressure is temporarily lowered, it is equivalent to prolonged shock. In fact, anything that produces chills and fever,

lowers blood pressure, but it is not the way to cure hypertension.

In conclusion, the doctor impressed on us his feeling that conservatism should govern our management of hypertension.

### PASSAIC COUNTY

I. Okin, M.D., Reporter

The *Passaic County Medical Society* held its regular meeting at School No. 13, Paterson, on January 8, at 9:00 p. m., with DR. SIGURD W. JOHNSEN, the President, in the chair. It was a combined meeting with the Passaic County Pharmaceutical Association.

The following members were elected to active membership: Dr. William Charney, Paterson; Dr. Orlo H. Clark, Passaic; Dr. Irving R. Hayman, Paterson; Dr. Edward C. Thompson, Paterson.

Dr. Edward W. Chudzik, Lyndhurst, was elected to associate membership.

Dr. Johnsen introduced MR. GEORGE KRECH, President of the Passaic County Pharmaceutical Association, and the speaker of the evening; DR. NORMAN PLUMMER, Assistant Professor of Medicine at the Cornell Medical School.

Dr. Plummer's topic was the "Use and Misuse of the Sulfonamid Drugs". He pointed out that sulfadiazine was the safest drug of the group; that the toxic reaction was less and its value, especially in pneumonia, was equal to or even better than the other sulfa drugs.

He mentioned the use of sulfa drugs in treatment, in prophylactics, and in surgery. He showed many lantern slides based on extensive experience at Bellevue Hospital and many questions were asked at the conclusion of his talk.

A large group enjoyed the presentation.

### SALEM COUNTY

Lee C. Hummel, M.D., Reporter

The Du Pont Country Club at Carneys Point, N. J., was the site of the December 19 meeting of the *Salem County Medical Society*. DR. E. E. EVANS presided over a well-attended meeting. The short business session was devoted largely to a discussion of ways and means for clearing and caring for casualties in the event of an attack in this area. As our county has several important defense industries, the gravity of the situation was fully appreciated and plans were freely discussed. Much concrete work has already been accomplished by the Defense Committee and more plans are being developed steadily.

An interesting scientific program was presented by MISS JANET G. ARMSTRONG, R.N., of the Children's Hospital in Philadelphia. She has been engaged in work on clinical uses of pooled human serums in whooping cough, mcasles, scarlet fever, etc. A film showing the production of human serum preserved by the lyophile process was presented and was interesting and timely. This type of serum is being used increasingly in the military services due to its stability and ease of transportation. Its life-saving qualities in severe shock and burns make it especially desirable for use in emergencies.

Dinner was served at the club.

# WOMAN'S AUXILIARY

## WOMAN'S AUXILIARY

Mrs. ASHER YAGUDA, Chairman Press and Publicity

### COMING EVENTS

#### ATLANTIC COUNTY

February 13, 1942, 8:45 p. m.

Place undecided

Speaker: Mrs. Allan Reick

Subject: Hobbies

Card playing

#### BURLINGTON COUNTY

March 2, 1942, 1:00 p. m.

Riverton Country Club

Election of officers

#### CAMDEN COUNTY

March 3, 1942, 2:00 p. m.

201 Westmont Avenue, Haddonfield

Election of officers

Speaker: Mrs. A. Haines Lippincott

Subject: Quiz program

One-act play; cast, Auxiliary members

#### ESSEX COUNTY

February 23, 1942, 2:00 p. m.

Academy of Medicine, Newark

Speaker: Miss Gertrude Neidlinger

Subject: Singing Satires

Tea

#### GLOUCESTER COUNTY

February 14, 1942, 1:00 p. m.

19 Hopkins Street, Woodbury

Luncheon

### STATE MEETING

An open meeting of the State Board was held on January 12 at the Trenton Country Club. There were 46 members present.

Mrs. Oswald R. Carlander presided at the meeting, which convened at 10:30 a. m. During the morning business session, county presidents and state chairmen read their reports. Mrs. Carlander made a special plea to the Auxiliary members to cooperate with the conservation of rubber program and to use their influence to further the wishes of the government in this project.

Mrs. David Allman, Chairman of Entertainment, requests all-out support from the counties while the members of the National Auxiliary are guests of the New Jersey Auxiliary at the A. M. A. meeting in Atlantic City in April.

A recess was called for luncheon and with the dessert, food for thought was provided by Dr. Henry A. Davidson, Editor of *The Journal of The Medical Society of New Jersey* in his talk to the members. Dr. Davidson has shown himself to be a loyal supporter of the Auxiliary and has been very helpful this year. He reviewed several projects which are really designated as our particular work and which we are often likely to forget. Dr. Davidson said, "Your most valuable public relations job is in your contact with lay organizations. Many clubs have magazines and you should suggest that medical topics be published in them. Work with the Program Committee to present medical speakers, preferably a doctor in your own county. Suggest the innovation of having a short paper read on a subject allied to medi-

cine. These are obtainable from the Red Cross, the files of The Medical Society or, better yet, develop your own." Another timely reminder by Dr. Davidson was to watch for adverse publicity in lay publications concerning physicians or medical practice. Many times we have been requested to clip these and too many of us fail to do so. The Medical Society should be given an opportunity to reply to these challenges or misstatements. Dr. Davidson explained the relationship between the Federal Government and organized medicine. He reminded us that by filling out the questionnaires, issued in August, 1940, the physicians were the first group in this country to register themselves for defense. The data compiled from this survey was placed at the disposal of the Federal Government. An enrollment blank appeared in the January issue of *The Journal*, by means of which doctors may indicate their immediate availability for government service. We are urged to ask our husbands to offer their services as teachers of Red Cross first aid courses. "The work of the Auxiliary is of major importance in implementing the work of the Medical Defense Program," said Dr. Davidson in closing.

Announcement was made of the open meeting of the State Board to be held in Newark on March 9 at the Academy of Medicine. All members are invited to attend.

Mrs. Carlander proudly displayed the President's Pin which was given by the "Fellowettes", the recently formed group of Past State Presidents.

The meeting was adjourned at 3:30 p. m.

## "G" Is for Gloucester County

These articles, written by the Presidents of the describe the procedures, aims and pet projects of

County Auxiliaries, are published each month and the County Auxiliaries.

Since the threat of war has become an actuality, our organization has definite aims and purposes ahead. As wives of physicians we stand ready to assume rôles very important to the defense of our country and the health of our citizens in our various communities. We are ready to help our County Medical Society in whatever they may ask us to do.

In November we had a successful card party with the entire proceeds donated to the American Red Cross. A number of our members are already active in the First Aid, Home Nursing, Motor Corps and other work in the Red Cross, and there are others who plan to take these courses in the near future. We also continue our social contacts in a simpler manner, as these prove of great value in times of stress and help to lighten the burden of war.

We have a Reciprocity Program planned for April and our speaker will be from the Gloucester County Home Demonstration Bureau on the subject of nutrition.

We plan to have several members of our County Medical Society give us short talks at our business meetings.

We have added a half dozen new members to our roster this past year.

Regardless of what the future may hold, we feel sure that America can never lose, and each and every member of our County Auxiliary stands ready and willing for whatever we may be asked to do, either as an organization or as an individual in our own community.

MRS. PAUL M. PEGAU, President,  
Gloucester County.

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## STATE NURSING ASSOCIATION IN DEFENSE

Conforming with our policy of keeping informed on things medical, we communicated with key members of the State Nursing Association to ascertain what was being done by that organization to aid defense. Much is heard and read of the shortage of registered nurses in the services and for civilian needs. It is well for the members of the Auxiliary to know that the State Nursing Association is today carrying out plans made long ago to expedite the supply of nurses to meet the needs of the wartime program.

In normal times the State Board of Nursing Examiners hold two examinations a year. Last June an extra examination was held so that graduates of nursing schools, finishing in the spring, would not have to wait until November for examination and registration. The results of the November, 1941, examinations were released in one month. The usual waiting period has been two to three months. This "speeding up" meant that 600 registered nurses were made available for services almost immediately. In January, 1942, the Board granted permission to all accredited schools of nursing to employ any graduate nurse, even though she is not registered.

A new pamphlet, now being distributed to all high schools and junior colleges, outlines the advantages of a nursing training and stresses the importance of obtaining that training in approved hospital training schools. Speakers

from the State Nursing Association are frequently sent to student body conferences at the high schools and colleges. Radio broadcasts are another medium for the dissemination of publicity for the Association. Guidance directors of high schools and colleges are being invited to inspect training schools in order to familiarize them with the recreational and educational facilities by these schools.

"Are the courses in training schools going to be shortened to meet the present emergency?" So far there is no indication that this will be done. It is felt that the most important part of the nurse's training is service and experience. Colleges which deal with theoretical instruction only can shorten their courses without detriment; but experience cannot be hurried. A student nurse in her third year of training is considered as valuable from a service standpoint as a graduate nurse. If this student is allowed to pursue her normal period of training, she can in an emergency release a graduate nurse for service outside the hospital.

The National League of Nursing Education has for more than a year been endorsing and arranging refresher courses for graduate nurses. In every community in this state there are hospitals where these courses are in session.

The State Nursing Association has its shoulder to the wheel of the medical bandwagon of defense.



## QUESTIONNAIRE

In October, 1941, questionnaires were sent to Auxiliary members requesting information concerning special training and availability for service in a national emergency. Three hundred and seventy-six members returned their questionnaires filled out. The result by counties is shown in the table below.

Dr. Thomas K. Lewis, President of The Medical Society of New Jersey, arranged a meeting, which was held at the Academy of Medicine in Newark on January 14, and at which it was decided to turn over to the Volunteer Office of the local Civilian Defense Councils the data compiled from the survey. Among those present at the meeting were Mrs. Oswald R. Carlander, Dr. LeRoy A. Wilkes, Dr. C. H. Schlichter and representatives of the American Red Cross and nursing organizations.

Excerpts from a letter written by Mrs. Carlander to the county presidents are as follows:

1. Take the outline prepared for your county from the results of the survey to your local Director of Civilian Defense with the suggestion that it be given to the Chief of the Emergency Medical

Service. Point out that your members are willing to serve in case of a disaster only.

2. Prepare. Call the President of your County Medical Society and tell him that you have members who would like to have refresher courses in the fields of nursing, clerical training in a hospital, or other technical training centering about the hospital.

3. Encourage your friends to take first aid courses or nurses' aides courses through the Red Cross.

4. If you are a trained person and do plan to take refresher courses, encourage your friends to take these, too, even though they do not belong to the Auxiliary.

5. Keep your questionnaires, which will be returned to you, safely on file. As your members take courses record their records on their original questionnaire.

These services will not be required except in cases of major emergency in the home area. It is assumed that the majority of doctors' wives are not available for remote service because of family duties and therefore there is no infringement on the activities of the Red Cross and similar organizations.

### SURVEY OF TRAINED PERSONNEL AVAILABLE IN THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

(Returns of 370 Questionnaires)

Counties	I. Trained Nurses	II. Trained Dieticians	III. Trained Technicians	IV. Clerical Training	V. First Aid Workers	VI. Untrained, Willing to Serve
Atlantic .....	4	0	0	12	2	17
Bergen .....	19	4	2	14	9	23
Burlington .....	9	1	2	6	3	15
Camden .....	14	3	1	16	2	36
Essex .....	11	3	1	8	5	14
Gloucester .....	9	1	3	7	0	5
Hudson .....	11	0	0	8	5	20
Mercer .....	4	1	1	12	4	16
Middlesex .....	5	0	0	4	2	18
Ocean .....	5	0	0	5	0	5
Passaic .....	19	2	0	14	6	20
Somerset .....	1	1	1	1	1	1
Union .....	4	0	0	4	2	8
Warren .....	3	0	0	2	0	3

#### Camden County

Mrs. J. N. Barroway, Chairman Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on January 6, 1942, at the home of Mrs. Max L. Weimann, in Haddon Heights. There were 45 members present. The President, Mrs. George B. German, presided.

The meeting was opened by singing the first verse of "The Star-Spangled Banner", led by Mrs. A. Lincoln Sherk.

Minutes of the last meeting were read by Mrs.

#### NOTICE: TO PUBLIC RELATIONS CHAIRMEN

The time of the radio program "Doctors at Work" broadcast by the National Broadcasting Company every Saturday has been changed from 5:30 p. m. to 5:00 p. m.

A. Gomersal Pratt and were approved as read. Mrs. German presented 14 new members and a special welcome was extended to them.

The Treasurer's report was read and accepted.

Mrs. Joseph E. Roberts read the proposed change of the Constitution and By-Laws of the Woman's Auxiliary to the Camden County Medical Society providing an increase of the annual dues from \$2 to \$3. It was moved, seconded and carried that this change be accepted, to be effective immediately.

Mrs. German appointed a Nominating Committee of five members.

The Corresponding Secretary, Mrs. A. Girton Kinney, read the following resolution drawn up by Mrs. Arthur J. Casselman:

Whereas, The Woman's Auxiliary to the Camden County Medical Society at the regular meeting on Tuesday, January 6, 1942, desire to express their deep regret of the death of Mrs. Lena Luda Fithian. Mrs. Fithian was a charter member and our only Honorary member. She was always faithful and loyal to the Auxiliary, and her jovial disposition and keen interest in the affairs of the Auxiliary will be missed by all who knew her.

Therefore, be it resolved, The Woman's Auxiliary to the Camden County Medical Society make permanent a record of this resolution by spreading upon the minutes of our society a copy of this expression of our regret.

A suitable copy of this resolution will be sent to a niece of Mrs. Fithian.

Mrs. German announced that she had 50 defense-stamp booklets, each containing one 25-cent stamp, for sale to members. These were all sold after the meeting. She invited the members to attend the Open Winter State Auxiliary Board Meeting to be held on January 12, 1942, at the Trenton Country Club; and the "Friendship Dinner" on January 19 at the Hotel Walt Whitman, Camden, N. J., sponsored by the Women's Clubs, and given to encourage coöperation of the Auxiliary with the Women's Clubs and other organizations.

The annual Card Party and Fashion Show is scheduled for Monday evening, March 2, 1942, at the Walt Whitman Hotel. Mrs. William Braun is acting as General Chairman.

Mrs. Oram R. Kline announced that the Public Relations Meeting will be an afternoon session held March 17, 1942, at the Camden Woman's Club, 424

Linden Street, Camden, N. J. Mrs. Kline replaces Mrs. Casselman, who had just resigned as Public Relations Chairman.

After the business meeting, Mrs. Henry R. Tatem introduced the guest speaker, Colonel A. P. Upshur, member of the Medical Corps of Tilton General Hospital near Camp Dix. He gave an interesting talk on Tilton General and other army hospitals, comparing peace and war-time needs. He spoke also of the Medical Corps personnel and equipment and the splendid work of the American Red Cross.

This was followed by a delightful social period, and tea was served by the Hospitality Committee, with Mrs. A. H. Lippincott and Mrs. A. M. Elwell pouring.

### Hudson County

Mrs. James M. Murphy, Chairman, Press and Publicity

The Tuberculosis Hospital at the Medical Center in Jersey City entertained 30 members of the *Woman's Auxiliary to the Hudson County Medical Society* at a luncheon on January 5, 1942, after which the regular meeting was held, presided over by the President, Mrs. A. C. Ruoff.

Dr. B. S. Pollack, Director of the hospital, welcomed the Auxiliary and spoke on the advance in the treatment of tuberculosis. He compared the results of the use of pneumothorax treatment during the last three years with the use of the same treatment in the preceding ten-year span. More patients were so treated with better effect than in the earlier decade. He described briefly the organization of this most modern and efficient hospital.

Following the luncheon, members of the medical staff conducted the group through the kitchen, clinic, x-ray department, library, museum, children's ward, pneumothorax treatment floor and the nurses' quarters.

The business meeting was held in the attractive auditorium of the institution. The Auxiliary decided to buy a \$1,000 Defense Bond as an expression of our sentiments in days like these. Pamphlets were distributed to each member to promote individual purchase of Defense Bonds and Stamps.

We are indebted to our efficient Program Chairman, Mrs. A. L. Kruger, for arranging this meeting at which a visual demonstration of the modern treatment of tuberculosis was made available to our members.



DISPARAGING REMARKS CONCERNING THE ability of the preceding physician, or shocked surprise that he should have omitted a test which the successor is making, are always poor policy, and seldom increase the patient's respect for the physician making them. When the patient asks directly if the previous physician did not err, it is always possible to explain that it is impossible to give an answer now, since the case might have shown a very different picture at the time the predecessor was in charge.—"Disease and the Man"—Lapham.



THE YOUNG PRETTY NURSE JUST OUT OF training, who has never traveled outside her own state, and who doesn't know Freud from Chopin, though excellent in nursing care, is still a poor companion to accompany a well-to-do and bookishly inclined spinster on a cruise. No better is the choice of a nurse, a middle-aged widow of keen intellect and excellent social grace but rather indifferent nursing ability, who is called to nurse the local contractor who has a badly injured leg, a streptococcus infection, a temperature spiking up to 104 but an I.Q. which never reached 60.—"Disease and the Man"—Lapham.

## BOOKS RECEIVED FOR REVIEW

- PERINEOPELVIC ANATOMY FROM THE PROCTOLOGIST'S VIEWPOINT. By R. V. Gorsch, A.B., M.D. Pp. 298. New York, The Tilghman Co. 1941. \$8.00.
- BEHIND THE MASK OF MEDICINE. By Miles Atkinson. Pp. 345. New York, Charles Scribner's Sons. 1941. \$3.00.
- HIPPOCRATIC MEDICINE; its spirit and method. By William Arthur Heidel. Pp. 149. New York, Columbia University Press. 1941. \$2.00.
- IMMUNOLOGY. By Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P. 2d ed. Pp. 639. St. Louis, C. V. Mosby Company. 1941. \$6.50.
- TOXEMIAS OF PREGNANCY. By William J. Dieckmann, M.D. Pp. 521. St. Louis, C. V. Mosby Co. 1941. \$7.50.
- SYNOPSIS OF GENITOURINARY DISEASES. By Austin I. Dodson, M.D., F.A.C.S. 3d ed. Pp. 302. St. Louis, C. V. Mosby Co. 1941. \$3.50.
- SYNOPSIS OF ALLERGY. By Harry L. Alexander, A.B., M.D. Pp. 246. St. Louis, C. V. Mosby Co. 1941. \$3.00.
- SURGICAL PRACTICE OF THE LAHEY CLINIC, Boston, Massachusetts. Pp. 897. Philadelphia, W. B. Saunders Co. 1941. \$10.00.
- MEDICAL CLINICS OF NORTH AMERICA; MILITARY MEDICINE. Three-year cumulative index, vols. 23, 24 and 25, 1939, 1940, 1941. Philadelphia, W. B. Saunders Co. Pp. 418. Paper, \$12.00 per clinic year. Cloth, \$16.00 per clinic year.
- DISEASES OF THE NERVOUS SYSTEM, described for practitioners and students. By F. M. R. Walshe, O.B.E., M.D., D.Sc., F.R.C.P. (London), Hon. D. Sc. Nat. Univ. Ireland. 2d ed. Pp. 325. Baltimore, Williams & Wilkins Co. 1941. \$4.50.
- CHINESE LESSONS TO WESTERN MEDICINE. A contribution to geographical medicine from the clinics of Peiping Union Medical College. Pp. 380. New York, Interscience Publishers. 1941. \$5.50.
- RADIATIONS AND WAVES; sources of our life. By Georges Lakhovsky. Pp. 142. New York, published by Emile L. Cabella. 1941. \$2.50.
- DUST OF OUR TIME and other poems. By H. Ameroy Hartwell. Pp. 123. Boston, Bruce Humphries, Inc. 1941. \$2.00.
- ABOUT OURSELVES; a Survey of Human Nature from the Zoölogical Viewpoint. By James G. Needham, Ph.D. Pp. 276. Lancaster, Pa. Jaques Cattell Press. 1941. \$3.50.
- AUTONOMIC NERVOUS SYSTEM; Anatomy, Physiology and Surgical Application. By James C. White, M.D., and Reginald H. Smithwick, M.D. Pp. 469. New York, Macmillan Co. 1941. \$6.75.
- PSYCHOLOGY OF DEALING WITH PEOPLE; serving the need of a feeling of personal worth. By Wendell White, Ph.D. 2d ed. Pp. 268. New York, Macmillan Co. 1941. \$2.50.
- THE 1941 YEAR BOOK OF PATHOLOGY AND IMMUNOLOGY. Pathology ed. by Howard T. Karsner, M.D. Immunology ed. by Sanford B. Hooker, A.M., M.D. Pp. 623. Chicago, Year Book Publishers. 1941. \$3.00.
- DIABETES MELLITUS. By Zolton K. Wirtschafter and Morton Korenberg. Baltimore, Williams & Wilkins Co. 1942.
- THE 1941 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. Ed. by Charles F. Painter, M.D. Pp. 432. Chicago, Year Book Publishers. 1941. \$3.00.
- BLOOD BANK AND THE TECHNIQUE AND THERAPEUTICS OF TRANSFUSIONS. By Robert A. Kilduffe, A.B., A.M., M.D., F.A.S.C.P., and Michael DeBakey, B.S., M.D., M.S., F.A.C.S. Pp. 558. St. Louis, C. V. Mosby Co. 1942. \$7.50.
- COMPARATIVE BIOCHEMISTRY. Intermediate Metabolism of Fats. Carbohydrate Metabolism. Biochemistry of Choline. Ed. by Howard B. Lewis. Pp. 247. Lancaster, Pa. Jaques Cattell Press. 1941. \$2.50.
- NEUROANATOMY. By Fred A. Mettler, A.M., M.D., Ph.D. Pp. 476. St. Louis, C. V. Mosby Co. 1942. \$7.50.

## BOOK REVIEWS

**Textbook of Pediatrics.** By J. P. Crozer Griffith and A. Graeme Mitchell. 3d ed. Pp. 991. Philadelphia, W. B. Saunders Co. 1941. \$10.00.

Completely new, modernized, and retitled, this most recent edition of an old favorite once more represents an essential item in the library of the student or practitioner. With the aid of recognized authorities in the many branches of the field, the authors have brought up to date and re-presented their material in the light of newer developments. The orientation of the volume has been changed, to emphasize the *care* as well as treatment of the child, both sick and well, and his developmental processes, mental and physical.

Pediatrics has come to mean that branch of medicine which deals with the growth and development as well as diseases of the child. The authors have fallen in step with this trend. Foremost among the innovations is the chapter on mental growth and development. Under this heading they consider

the intricacies of the emotional pattern, the educational and psychologic aspects of play, the prophylaxis of mental ills, and the problems of adolescence.

Because of the scope of the work, the authors have omitted all bibliography, feeling that an inadequate set of references would be only a gesture without useful purpose. To overcome this defect they have collaborated with the Society for Research in Child Development in preparing, in monograph form, a bibliography for those who seek additional data.

The authors have divided their material into two main divisions; general subjects, and diseases of the various body systems. In this manner they have succeeded in presenting in well-rounded and entirely readable form a comprehensive, orderly, and easily understandable textbook on an all-inclusive subject: the development and diseases of the child.

WALTER L. MITCHELL, JR., M.D.



**The Doctor Takes a Holiday;** an autobiographic fragment. By Mary McKibbin-Harper, M.D. Pp. 349. Cedar Rapids, Iowa, Torch Press. 1941. \$2.50.

As the title indicates, this is the story of the travels of a physician. After a short chapter on the beginning of the journey in Sweden and Paris, she gives a detailed account of life as she sees it in Palestine. The bulk of the book deals with India and China. Aside from observations of hospitals and conversations with native and missionary physicians, there is nothing new. The tale is interesting in spots but not unusual. It is just another travel book.

**Handbook of Communicable Diseases.** By Franklin H. Top, A.B., M.D., M.P.H. and collaborators. Pp. 682. St. Louis, C. V. Mosby Co. 1941. \$7.50.

The arrangement of this volume differs from that of the average book on communicable diseases. This makes it an interesting approach to the subject. Section 1, reviewing "general considerations", covers much ground concisely and gives a workable plan applicable to almost any locality. Preventive measures, including serums and vaccines, are well presented. The review of nursing care and management is complete. Top's classification of communicable and infectious diseases, by the common portal of entry, is striking and will apply as well as any other until we have a better understanding of the diseases involved and their manner of spread. The description of each of the diseases follows an orderly pattern, covering some points in the history of the disease, its epidemiology, immunity, pathology, symptomatology, clinical types, complications, prognosis and treatment. All phases of this have been modernized. A bibliography follows each article and a glossary of terms and tables completes the book.

As a ready reference hand-book this is a splendid volume. It is ideal for nurses, public health inspectors and the general practitioner. The more specialized and unusual aspects of the subject are omitted.

J. W. GARDAM, M.D.

**The 1941 Year Book of Pathology and Immunology.** Edited by Howard T. Karsner, M.D. Immunology, ed. by Sanford B. Hooker, A.M., M.D. Pp. 623. Chicago, Year Book Publishers. 1941. \$3.00.

One of the easiest and most efficient ways of keeping up with the advances in medicine is to read the year books. The 1941 volume on pathology and immunology serves the purpose well and contains a judicious selection of important advances, including those relating to hypertension and renal disease, transfusion reactions and iso-immunization, pneumococcal infections, meningitis, tetanus, influenza, poliomyelitis, and such advanced subjects as electrophoretic characteristics of pathogenic and non-pathogenic staphylococci, and the use of the electron microscope in bacteriology. The volume is recommended to all practitioners.

C. ABBOTT BELING, M.D.

**Essentials of General Surgery.** By Wallace P. Ritchie, M.D. Pp. 813. St. Louis, C. V. Mosby Co. 1941. \$8.50.

This book reveals the attitude and practices of the surgical department of the University of Minnesota Medical School. The material was compiled under the direction of Dr. Owen H. Wangensteen and written for the undergraduate medical student. It should also be of great value to any practitioner who wishes to review the general subject of surgery. It will be helpful to surgeons preparing for the examinations given by the American Board of Surgery. Most of the material is written clearly and concisely by Dr. Ritchie, while some of the chapters in the surgical specialties have been written by other members of the staff of the University of Minnesota Medical School.

The work is highly recommended as a text book in surgery for medical students and for physicians who wish to review surgical practice from one of the most outstanding surgical clinics in the country.

EDWARD M. FINESILVER, M.D.

**Cancer of the Face and Mouth; Diagnosis, Treatment, Surgical Repair.** By Vilray P. Blair, M.D.; Sherwood Moore, M.D., and Louis T. Byars, M.D. Pp. 599. St. Louis, C. V. Mosby Co. 1941. \$10.00.

"Though there are no statistics suggesting that it is as effective as an early properly performed excision, there are many circumstances which can render x-radiation the more appropriate, dictated by either the stage of the disease, the condition of the patient or his wishes."

The radiologist, being rarely concerned with surgery, needs to coördinate his work and thought with that of the surgeon. This book will aid in accomplishing this. The converse is equally true.

Every physician should examine this unpretentious exposition of this subject. The additional clarification of his thinking and an early realization of results to be expected might be life-saving in many cases.

To a detailed, careful review of cancer of the face and mouth, the authors add 260 plates of subjects and 64 diagrams of operative procedures. A compilation of the records of 780 patients of the late Ellis Fischel rounds out the book, and forms a basis for the surgeon specializing in this work to evaluate his own results.

EDGAR P. CARDWELL, M.D.

**Synopsis of Genitourinary Diseases.** By Austin L. Dodson, M.D., F.A.C.S. 3d ed. Pp. 302. St. Louis, C. V. Mosby Co. 1941. \$3.50.

The third edition of this work brings it up to date in the field of chemotherapy and revises the section on the formation of urinary calculi, thus definitely increasing its value. The diagrammatic representation of anatomy and pathology makes it easily understood. The sections on treatment, particularly by drugs and diet, are excellent. It is a valuable text for medical student and nurse and a helpful reference work for the busy general practitioner.

W. L. JAMES, M.D.

**Infant Nutrition;** a Textbook of Infant Feeding for Students and Practitioners of Medicine. By William McKim Marriott, B.S., M.D. Revised by P. C. Jeans, A.B., M.D. 3d ed. Pp. 475. St. Louis, C. V. Mosby Co. 1941. \$5.50.

This classic is a splendid summary of the present-day knowledge of infant nutrition. The chapters are concise, clear and authentic. Historical data and theories on debatable subjects have been omitted. The book opens with a discussion of those facts on growth and development which one must know to take care of infants. The nutritional requirements including the vitamins are all admirably summarized in one short chapter. Readers are warned against excessive dosage with cod-liver oil preparations; an opinion not shared by all pediatricians. Of particular importance is the subject of diet for normal infants with specific instructions as to the most suitable age to initiate the vitamin supplements and just when to introduce cereal, vegetables, fruits and other items. This phase of the subject is an authentic description of the current trend in feeding infants and so well written as to be easily grasped by those who find this part of pediatrics hard to understand. The various infantile nutritional disorders: colic, vomiting, constipation, diarrhea, malnutrition, celiac disease, rickets, tetany, scurvy and allergy, are given in a brief but masterly manner. The chapter on food allergy well points out the opinion today of the superiority of elimination diets over skin tests, a fact borne out in practice. The work concludes with a description of technical procedures used in correcting nutritional disturbances in infancy, such as a detailed method of collecting and culturing stools in a suspected case of bacillary dysentery, gavage feeding and continuous venoclysis. This is an authoritative publication clearly presented and merits great praise because it will do much to raise the standards of infant nutrition.

L. CHARLES ROSENBERG, M.D.

**Allergy in Clinical Practice.** By staff-members of the Cleveland Clinic under the direction of Russell L. Haden, M.D., F.A.C.S. Ed. by J. Warrick Thomas, M.D., F.A.C.P. Pp. 354. Philadelphia, J. B. Lippincott Co. 1941. \$5.00.

Here the specialists in several branches of medicine have coöperated with the allergists in the differential diagnosis of allergic diseases arising in their fields. The problems are grouped under seventeen headings involving the respiratory mucous membranes, the skin, the eye and adnexa, the gastro-intestinal tract and the glands of internal secretion. Uncommon manifestations of allergy are discussed. Each case history and examination is presented clearly and briefly, with allergy study, management, and comment. Color plates assist in visualizing many of the allergic diseases. Methods of diagnosis and treatment are not given in detail.

The busy clinician may find this volume of considerable value in solving a few more of his complex problems in medicine.

CLIFFORD G. WESTON, M.D.

**Eye Hazards in Industry.** By Louls Resnick. Pp. 347. Columbia University Press. New York. 1941. \$3.50.

This book, written by a non-medical man well versed in industrial eye hazards, has been published at an opportune time. Every medical man who has anything to do with industry should read this book. While intended primarily for safety engineers, there are many suggestions for the plant physician and the ophthalmologist.

The first chapter, "The Problem of Eye Hazards", tells us that there are about 300,000 eye injuries every year in American industries and it is the opinion of experts that 98 per cent of these are avoidable.

In chapter two, reference is made to a report of eye accidents by a member of The Medical Society of New Jersey, Dr. Elbert S. Sherman. His analysis reveals that the greatest ratio of eye injuries occurs in machine shops and machine tool plants. In chapter three, the discussion of diseases from radiant energy is good, as is also the lighting discussion. Material on defective vision is well reviewed and well illustrated. The advantage of good vision and the increased efficiency, when employees are properly fitted with glasses, is thoroughly discussed.

The chapter on first-aid analyzes the harm done by amateur removal of foreign bodies from the eyes, by delay in reporting injuries, and by the return of men to work before they have made a complete recovery.

To the oculist and plant physician who has never delved into this phase of eye injuries, the book will reveal many interesting problems on the use of mechanical guards. The "mandatory goggle rule" in many plants has resulted in a marked decrease in eye injuries.

The reviewer was especially interested in this volume because the war has suddenly thrown him into a position where he must treat eye injuries among 30,000 ship-yard workers. With their increased enthusiasm and the emphasis on quick production, the accident rate has apparently increased. This book is a timely warning that relaxation of safety measures will result in loss of time, decrease in production and untold sorrow and misery to the injured.

This review cannot be concluded without the mention of the death of the author, Louis Resnick, on March 18, 1941. During his last illness he finished this manuscript, as a final monument to his life's work.

HAROLD D. BARNSHAW, M.D.

**Complete Weight Reducer.** By C. J. Gerling. Pp. 246. New York, Harvest House. 1941. \$3.00.

All phases of the reducing problem are reviewed in this book, following a dictionary arrangement. It contains menu and weight charts, and under different headings gives the caloric counts of many different kinds of foods. It is full of sound advice and should be referred to by all who contemplate losing excess fat.



**Functional Pathology.** By Leopold Lichtwitz, M.D. Pp. 567. New York. 1941. Grune and Stratton, Inc. Price \$8.75.

Despite its awe-inspiring title, the book reads easily. Its orientation is announced in a prefatory remark: "It is deliberately written from a very personal viewpoint; on many occasions it does not harmonize with widely accepted—or what has been termed orthodox—opinion."

A chapter on endocrinology includes a review of the chromaffin system and its relation to the sympathetic nervous system, as well as important discussions of the concept of humoral transmission of nerve impulses. A novel explanation of congenital disorders based upon experiments with plant hormone is offered. Heat regulation and metabolism are discussed in special chapters. Included are sections on water and carbohydrate metabolism.

The chapter on the Pathology of Intracellular Oxidation should be read by every physician. At best, the subject is complicated and confusing. The author, however, in his illustrative method of presentation, stresses only the pertinent facts and thus clarifies the important aspects of this vital function. Two chapters on the mechanism of defense are extremely important from both practical and theoretical aspects.

The discussion of gout is valuable in that the malady is considered as a systemic disease. This is in agreement with the "retrocedent gout" of the English authors and will be of considerable help in understanding some of the less common manifestations of this disorder. The chapter on obesity contains many modern and novel ideas. In addition, there are chapters on thyroid gland and its disturbances, the mechanism of arthritis, disorders of the skeleton, pluriglandular diseases; blood pressure, hypertension and kidney function, angiospastic diathathesis, blood diseases and hepatic disorders.

This book is highly recommended and will prove itself of great value, not only to the general practitioner, but also to those in specialized work who have a broader vision and are accustomed to refer to subjects other than those in their limited field.

WILLIAM ANTROPOL, M.D.

**Diseases of the Nervous System; Described for Practitioners and Students.** By F. M. R. Walshe. 2d ed. Baltimore, Williams and Wilkins Company. 1941. \$4.50.

The author has achieved an outstanding success in his book. The first edition, published in September, 1940, was given such a favorable reception that its author found it necessary to prepare a second.

This second printing contains information on the tissue reactions of the nervous system and further data on sensory, visual and speech functions not contained in the first edition. It also deals more fully with pituitary disorders and intracranial tumors in addition to changes and additions on the subjects of acute infectious diseases of the nervous system, head and spinal injuries, and lesions of the spinal nerves. The volume contains a clear and concise presentation of the general principles of neurologic diagnosis and a descriptive account of the more common diseases of the nervous system.

The last chapter, devoted to the psychoneuroses, should prove of value not only to students and practitioners, but also to those interested in the nervous disorders following industrial accidents in relation to workman's compensation and liability claims.

CHRISTOPHER C. BELING, M.D.

**Dark Legend: A Study in Murder.** By Frederic Wertham, Director of Mental Hygiene Clinic, Queens General Hospital. Ed. 1. Duell, Sloan & Pearce, New York City. 1941.

The opportunity to delve deeply into the motivation of the criminal is rare. Few competent studies have been made of the early experiences, life history and motives of those found guilty of major crimes. Statistical reviews have been reported from time to time and an occasional psychoanalytic study has been published. A few autobiographical analyses have appeared, but these are usually self-serving and lacking in accuracy.

This book represents an investigation of a boy guilty of matricide. Dr. Wertham was fortunate in having had long and intensive contact with the case and reached a degree of understanding of the motives involved seldom afforded the casual observer. He has taken his material and welded it into an interesting, realistic picture, carefully trimming off irrelevant material. We see the important life experiences which have influenced the subject up to the point where he was driven by his obsessional trends into the final act of murder. In the later chapters of the book, the historical information is interpreted from the psychiatric point of view in terms which the average intelligent reader can well understand.

This book is no "thriller". It is not light reading nor is it entertainment. It is, however, thought provoking and informative. It should be read by those who recognize that behavior is the interaction between personality and life experiences. It will prove to be interesting reading.

LEWIS H. LOESER, M.D.

## OBITUARIES

### DR. HOWARD F. PALM

Dr. Howard F. Palm, Dean of Camden County Physicians, died on January 2 at the age of 86. Dr. Palm is a former President of the Camden County Medical Society and a graduate of Jefferson Medical College, class of 1881. He had conducted a clinic at the Camden City Dispensary for more than half

a century, and until a week before his death he had been actively engaged in the treating of patients. A native of Pennsylvania, Dr. Palm came to New Jersey in 1882, and had been in practice here since.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

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No. 2

THE number of persons whose pulmonary tuberculosis has been arrested through the aid of thoracoplasty is steadily increasing. They will require medical surveillance for the rest of their lives. They are not immune to other diseases. Since any doctor may be called on for advice, it is desirable that all members of the profession be familiar with the changes in the thorax which are brought about by thoracoplasty.

### RESULTS OF THORACOPLASTY

In advanced tuberculous disease, tissue destruction and cavity formation have taken place, the elasticity of adjacent segments of the lung is frequently reduced and the volume of the healthy lung is so reduced that it is incapable of filling the unyielding thoracic space. How can healing take place under such conditions?

Pulmonary cavities must be closed and remain closed. Fibrous tissue must not tear under the strain or ordinary thoracic movement, to insure against reactivation or hemorrhage. The scar must be solid, but at the same time its contraction should not pull thoracic viscera out of position to the extent that cardiorespiratory function is impaired. Certain patients are fortunate enough to make these adjustments spontaneously, arrest the process and enjoy moderate activity without reactivation. For a second group the problem has been solved by an adequate pneumothorax (or other temporary measure) which is maintained indefinitely with safety. There is a third group to which thoracoplasty is not applicable; patients who have such extensive disease and so distributed as to make it technically impossible to bring it wholly under control by any single method or combination of methods, must be excluded from this discussion.

A significant proportion of the tuberculous sick will not fall in the foregoing categories. The health of patients in this fourth group can be restored with surgical help. They are those patients who suffer from advanced disease with irreparable pulmonary damage.

A discrepancy exists between the volume of healthy lung and the volume of the thorax. Temporary measures have failed or present no reason-

able chance of being effective. They have an equivalent of two healthy pulmonary lobes, the two on one side or one on each side. Preferably, the disease is stable. The thoracic cage can be refashioned and the diseased lung released from its anchorages. The permanently altered position of the chest wall will provide a permanent collapse.

Modern thoracoplasty will accomplish the following:

1. Fibrous tissue is released, permitting cavity closure.
2. Pulmonary tissue which has been partially damaged but not totally destroyed, whose elasticity has been impaired by fibrosis, is relaxed.
3. Limitation of motion is imposed on the diseased lung.
4. The collapse of the disease can be made highly selective with conservation of healthy portions of the lung.
5. Disturbances due to distortion of the thoracic viscera such as upward displacement of the lower lobe and lateral displacement of the heart and great vessels, are corrected.

All of these readjustments are common accomplishments of a free pleura pneumothorax and thoracoplasty. In addition to these considerations, there are added benefits which are unique for thoracoplasty:

6. Thoracoplasty adjusts the thoracic volume so that it comes to equal the volume of the healthy lung. In other words, the functionless portion of lung is placed under permanent control.

7. The risk of tuberculous or mixed empyema developing in an artificially maintained air space is eliminated.
8. The risk of spontaneous pneumothorax on the side of treatment is greatly lessened.

The ultimate fate of patients treated by thoracoplasty cannot be determined until more time has elapsed. However, a preliminary study made of patients treated successfully by thoracoplasty and discharged with the consent of their medical advisers, is most encouraging. Of 107 patients discharged five or more years, 94.4% are living; 2.8% died of tuberculosis and 2.8% died of other causes. Of 315 patients discharged under five years, 97.8% are living; 0.3% died of tuberculosis and 1.9% died of other causes.

While exactly comparable end results are impossible to find, it is fair to assume that the severity and extent of the process from which the groups under discussion suffered, were more threatening than those of the average patient undergoing sanatorium treatment. Yet, they seem to fare better, for a study of 6,906 patients discharged alive from various sanatoria in this country revealed that only 60% of those discharged with consent were living after a period of five years.

In support of the belief that permanent collapse increases the chances for lasting results, the author quotes Roberts from the Brompton Hospital Reports for 1936 as follows: "It is shown that the chance of surviving five years in B 3 cases (not

defined in the article) treated without collapse was 23.7%; with pneumothorax, 55.3%; and with thoracoplasty, 66.6%. Thus, the expectation of living five years is approximately three times as great in cases submitted to thoracoplasty as in the average B 3 case."

A questionnaire sent to patients treated by thoracoplasty and who had been discharged with consent, brought 293 replies. The great majority considered themselves well and were glad they had had a thoracoplasty; 83% were able to work; 70% declared they had no limitation of arm or shoulder motion. Many letters which accompanied the questionnaire replies stated that the scar and changes in contour of the chest constituted a small price to pay for restoration of health and many stated that their only regret was that the operation had not been performed sooner.

Several refinements of thoracoplasty have been made since de Cernville performed the first thoracoplasty in 1885. These include lung palpation at operation, specific mobilization and the liberation of anchoring structures over areas of disease, preservation of periosteal elements and subtotal scapulectomy to minimize deformity in partial thoracoplasty.

(The article is well illustrated with photographs, radiographs and diagrams.)

*Permanent Collapse Therapy in Pulmonary Tuberculosis*, Richard H. Overholt, M.D., *Jour. of Amer. Med. Assn.*, Nov. 15, 1941.

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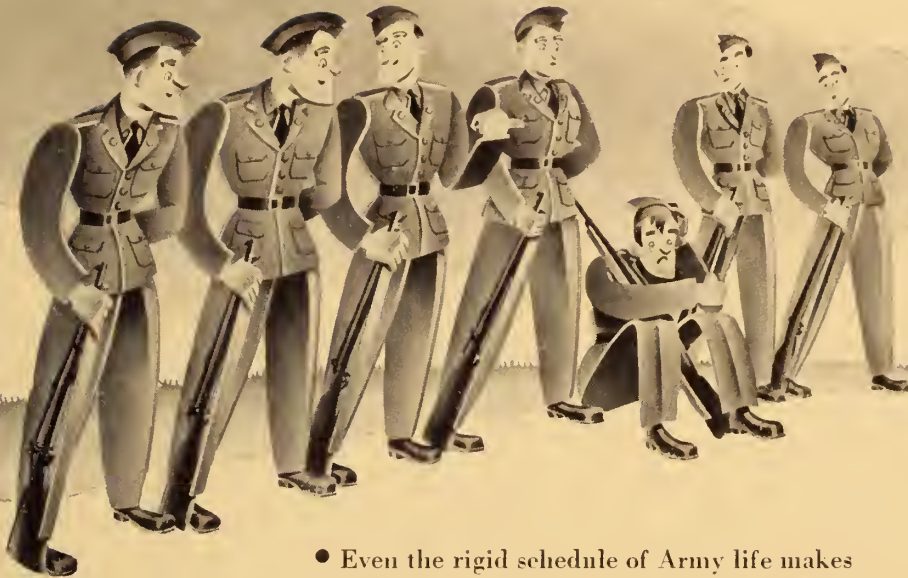
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### CONTENTS—Page 129 to 182

#### EDITORIALS—

COUNTY SOCIETY BULLETINS	129
THE SPECIALIST	130
PRECEPT AND PRACTICE	130

#### THE WAR—

PROCUREMENT AND ASSIGNMENT—William J. Carrington, M.D.	131
Attention New Jersey Physicians!	135
Medical Defense During Air Raids	136

#### ANNUAL MEETING—

176th Annual Meeting	137
Preliminary Program	137
Dinner Dance Reservation	137

#### ORIGINAL ARTICLES—

GASTROSCOPY AND THE GENERAL PRACTITIONER—Theodore S. Heineken, M.D., Bloomfield, N. J.	138
TRAUMATIC RUPTURE OF A HYDROCELE WITH CASE REPORT—Hugh F. Cook, M.D., and George F. Hewson, M.D., Newark, N. J.	142
CIRCULATION TIME AND VENOUS PRESSURE—Edward C. Klein, Jr., M.D., Newark, N. J.	144
THE PLACEMENT OF CARDIOVASCULAR CASES IN INDUSTRY—Max Greenberg, M.D., Linden, N. J.	147
A LESSON FROM A DEATH CERTIFICATE—No. 39	151
RADIOLOGY IN OBSTETRICS. Maternal Welfare Article No. 68—H. J. Perlberg, M.D., F.A.C.P., Jersey City, N. J.	152

#### STATE ACTIVITIES—

THE MODERN TREND TOWARD BETTER ORGANIZED MEDICAL SERVICES—LeRoy A. Wilkes, M.D.	155
Advisory Committee on Child Health	158
Advisory Committee on Conservation of Vision	158

#### STATE ACTIVITIES—

State and Municipal Health Officials' Annual Meeting	159
Society of Surgeons of New Jersey	159
With New Jersey Medical Authors	160
The Eye-Sight of the Worker	161
American Academy of Pediatrics	161
Child Health Day Proclamation	162
Connecticut State Medical Society Selects Medical Personnel	162
Employment of Graduate Nurses	162
U. S. Pharmacopoeial Convention	163
What Is Happening to Botanical Drugs?	163

#### OBITUARIES

164

#### LETTERS TO THE JOURNAL

166

#### THE BULLETIN BOARD

167

#### COUNTY SOCIETY REPORTS—

Atlantic, Bergen	168
Burlington, Cape May	169
Cumberland, Essex, Gloucester	170
Hudson, Hunterdon, Mercer	171
Middlesex, Monmouth	172
Morris, Ocean, Passaic	173
Somerset, Union	174
Summit Medical Society, N. N. J. Dermatological Society	175

#### WOMAN'S AUXILIARY—

Coming Events	176
War—Morale—Thumbs Up	176
"H" Is for Hudson County	177
Conventions Galore	177
County Auxiliaries	177

#### THE BOOK SHELF

179

#### TUBERCULOSIS ABSTRACTS

181

Roster of Officers, Advertising Page 3a

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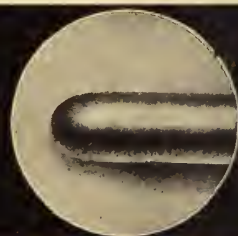
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Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

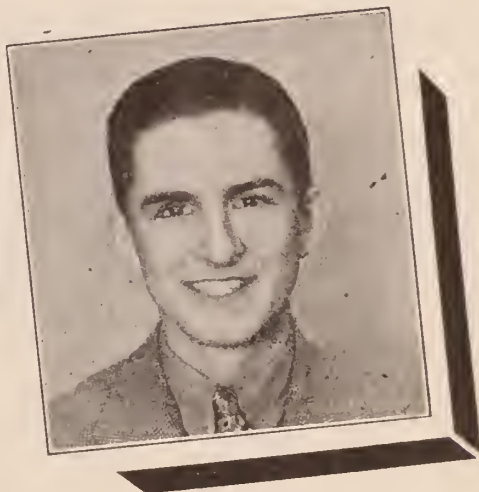
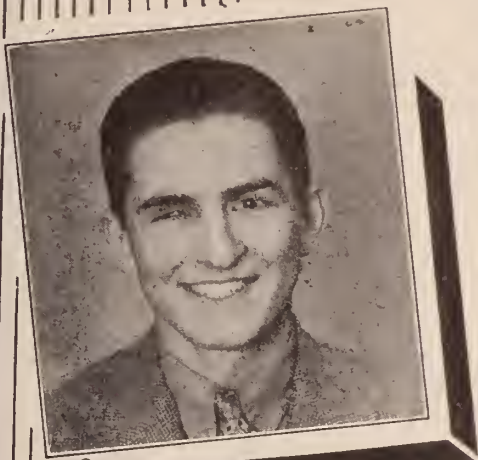
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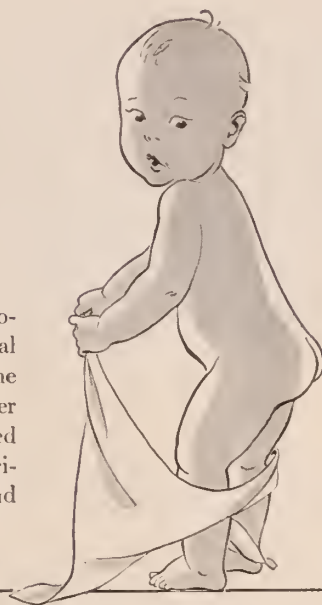
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	MINIMAL REQUIREMENTS	BIOLAC FEEDINGS
PROTEIN (gms./lb. body weight) . . .	1.4 to 1.8* . . .	2.2†
CALCIUM (gms./day) . . . . .	1.0* . . .	1.0
IRON (mgms./100 calories) . . . . .	0.75 . . .	1.25
VITAMIN A (U.S.P. Units/day) . . . .	1500. . . .	2500.
VITAMIN B <sub>1</sub> (U.S.P. Units/day) . . . .	83. . . .	85.
VITAMIN B <sub>2</sub> (mgms./day) . . . . .	0.5 . . .	2.
VITAMIN D (U.S.P. Units/100 calories) .	50. . . .	63.

\*The Food & Drug Administration has not promulgated minimum requirements for protein and calcium in infancy. The values shown are those recommended by the National Nutrition Conference.

†When Biolac formulas are fed in the amount of 2½ fl. oz. lb. body weight.

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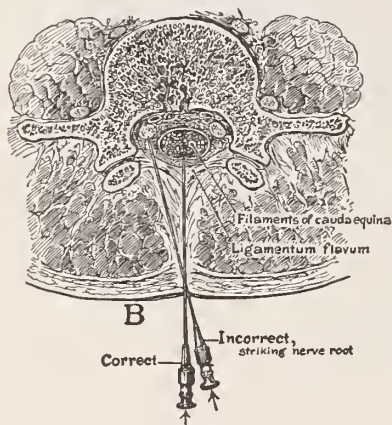
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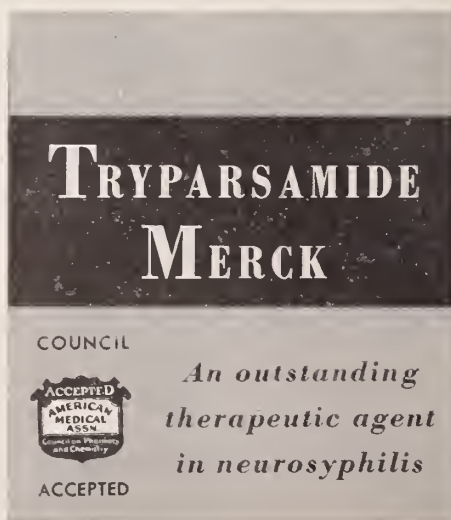
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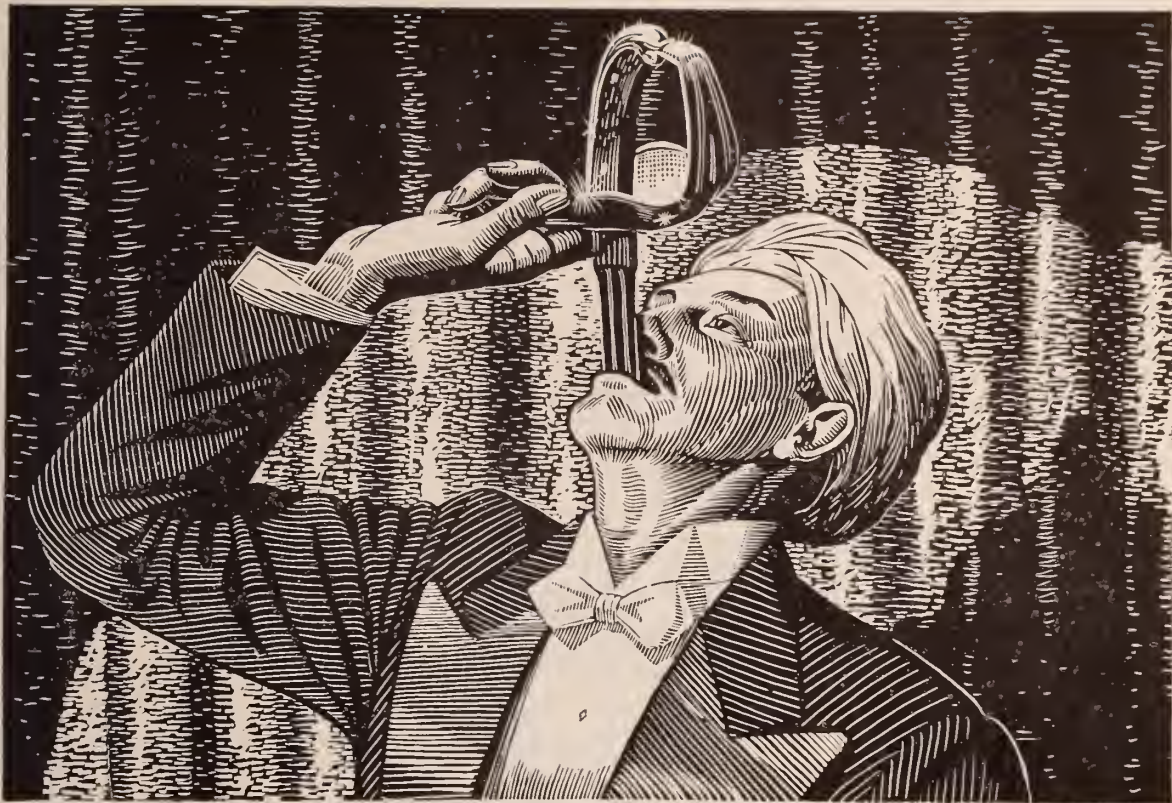
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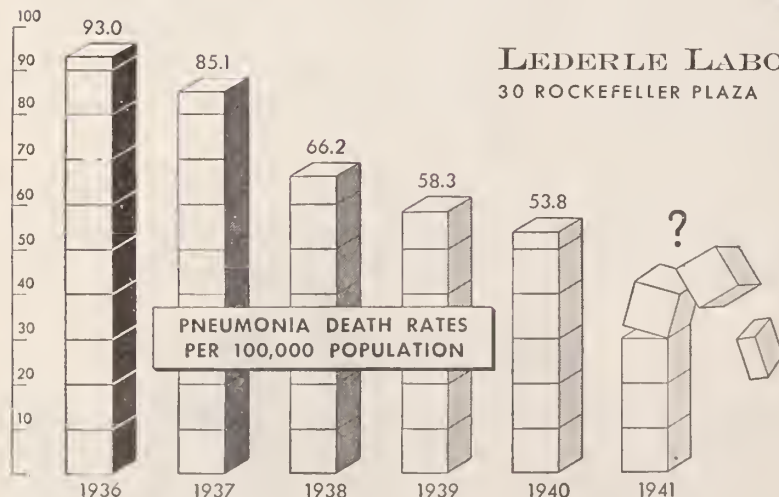
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**Q.** When I serve a dish of canned peas or spinach or some other canned vegetable to a patient, how can I know how much ascorbic acid the patient is getting?

**A.** I couldn't assign a definite numerical value. All vegetables have an upper and lower limit of ascorbic acid content. This probably is also true for their other essential nutrients. The ascorbic acid content of a given sample is determined by a number of factors, like variety, state of maturity when picked, soil, weather, and what happens to the vegetable between the time it is harvested and served to the patient. It is very likely that canned vegetables are fully equal in ascorbic acid content to kitchen-prepared vegetables. I suggest you be guided by reliable publications on the ranges of vitamin contents in canned foods. (1)

American Can Company, 230 Park Avenue, New York, N. Y.

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- (1) 1936. Food Research 1, 3  
 1936. Ibid 1, 231  
 1938. Nutrition Abstracts and Reviews 8, 281  
 1939. The Canned Food Reference Manual,  
 American Can Co., New York.  
 1940. J. Am. Diet. Assoc. 16, 891



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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**NON-SEPARATING ★**  
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PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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UNDER THE  
DIRECTION OF THE  
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

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## COUNTY SOCIETY BULLETINS

All but four of the County Medical Societies of New Jersey have their own bulletins. The County Bulletin should be the pocket companion of every member of the Society. This *Journal* is necessarily devoted largely to the presentation of scientific papers and of organizational activities on a state-wide front. However, comings and goings of the local profession, hospital staff meetings, the less well-advertised medical lectures, County Medical Society meetings, personal notes about brother practitioners in their own communities, and the more detailed activities of the County Societies necessarily receive less space in a state journal. Yet these features reach intimately into the professional life of every doctor. It is interesting to know, for example, who was promoted from adjunct to associate on what staff in your own hospital; to know what the Council or the Executive Committee of your own County Society is doing; to read what the officers of your County Society have to say; to see the names of the doctors who have recently

joined your organizations — and these items are found only in your County Bulletins.

Surely every county society can publish a bulletin. The smallest county society in the state has an excellent periodical—"The Journal of the Cape May County Medical Society", and if the smallest society can issue a periodical like that, the others—all larger—can do as well. The bulletin need not be elaborately printed on glossy paper. It may, if it meets the needs, be mimeographed. But it should be distributed at regular intervals so that members learn to look for it and expect it. Bulletin editors should learn how to secure the details of past and future meetings from the county society officers. Arrangements should be made to transmit to them, items of interest coming out of staff meetings of local hospitals.

The Publication Committee of The Medical Society of New Jersey stands ready to assist any county society in the establishment of a bulletin. We can help

in recommending page size, format, type size, type style, methods of securing information, editorial techniques, and methods of distribution. And we are in position to help county societies expand bulletins already in existence. The Editorial Office will forward material suitable for publication to any county society which requests it.

The county society bulletin should serve four functions:

(1) A channel of information from the officers to the members: a method whereby officers of the county societies can report to their members.

(2) A medium whereby members can transmit ideas for the welfare of the society to their officers.

(3) A forum for the airing of ideas on local medical problems.

(4) A portable bulletin board for information of local medical interest.

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## THE SPECIALIST

A specialist is one whose specialized interest, aptitude, training, experience and opportunities have fitted him to do especially well within a limited field in which his ability is demonstrated to an extent which causes certain people to seek his personal services and occupy his full time.

Specialists exist outside the medical professional, as well as within, and medical men *themselves* often become outstanding specialists in administrative and other fields. In some of these fields their medical knowledge and experience is of decided advantage—though of secondary importance in their success to their administrative ability. An M.D. hospital

administrator and a medical organization's executive are still worthy members of their profession; ethical and capable men who merit the fullest confidence and recognition of their colleagues. These M.D.'s are simply a new order of specialist by virtue of special study and experience devoted to a field more recently established and approved by medical leadership. Their work is in the interest of the profession. They are bound by the aims, objectives, principles, and approaches first approved by the Society. It is the accumulated experience and the practical advice of the trained executive which is of value in the final selection of the plans and procedures by which these aims and purposes may be achieved.

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## PRECEPT AND PRACTICE

The annual physical examination is an alluring proposal—to the physician—but apparently the patient still views it as an expenditure he does not wish to make out of his often very limited funds. This is entirely understandable when we consider what a small proportion of our own profession seeks and secures the constantly recommended annual physical examination. We doubt that we carry much

conviction in our statement that this is truly economic and advisable, when we ourselves neglect to put our precept into practice, even when, through professional courtesy, there is no expense involved.

We would not withdraw our endorsement of the periodic physical check-up but we doubt the effectiveness of such advice until we are more convincing in our own application of it.



## THE WAR

### PROCUREMENT AND ASSIGNMENT

By WILLIAM J. CARRINGTON, M.D., Second Corps Area Committee

Civilian doctors in the United States are bewildered, wondering what is going to happen to them. They ask, "How does the war affect me? Where do I come into the picture? Which comes first, duty to country or duty to wife and children? Father and Mother, who sent me to school, are old and feeble and entirely dependent upon me. Who will take care of them if I go? After all the years of preparation and the long lean years of waiting, I have finally established a practice. My staff position will be kept for me, but what about my private patients? Refugee physicians, who are aliens, are not wanted in the Army. Will they stay at home and lap up the cream of my practice? And what about commitments, the note, the mortgage, the bank loan? Who will pay my insurance premiums? Will my entrance into the war spell financial ruin?"

Let me answer some of these questions at once. First, will my practice remain intact while I am away? Certainly not. The experience of doctors who participated in World War I varied. Good doctors who were good medical officers came back with added prestige and soon built better practices than they had when they went away. No other doctor, no matter how loyal to you, can hold your practice together for you if you are away for any length of time.

Second, aliens are not acceptable in the Army and Navy Medical Corps, but they are subject to the draft and we have the promise of Washington that not one refugee physician will be permitted to stay at home. Every last one will be sent somewhere on federal business.

Third, commitments.—The Soldiers and Sailors Act offers some protection. The Bureau of Legal Medicine of the A. M. A. explained the civil rights of persons in military service in the *Journal of the A. M. A.* of January 24, 1942. In brief, taxes, notes, loans and mortgages are uncollectible for six months after honorable discharge but interest is cumulative.

Fourth, insurance.—A man entering service may collect, according to the type of insurance and the length of time in force, (a) the cash surrender value of his policies if any; (b) a paid-up policy for less than the face amount of his insurance; (c) extended term insurance for the full amount; (d) he may borrow from the insurance company some of the cash sur-

render value to pay the premiums; or (e) he may borrow the money at 5 per cent interest from the government to pay the premiums on policies up to \$5000. If he dies within the year, his estate receives \$5000 less the amount of the premium and interest which are paid by the government. Finally, he may take out government insurance up to \$10,000 at minimum rates. Inasmuch as individual cases vary, the sensible procedure is to secure the advice of a qualified life insurance agent.

Every doctor must answer for himself the question whether to volunteer as an officer or be drafted as a private. Certain unpleasant facts bear directly on the answer.

1. This nation is up to its neck in the most desperate war of history. It is an all-out, not a half-out war. It cannot be won by lend-lease billions. It cannot be won by proxy but only by our own fighting men.

2. The government has the power of life and death and will use all doctors, young and old, like knights on a giant chessboard.

3. Our armed forces will require doctors in numbers heretofore unknown. That means 6.5 doctors for each 1000 men. This ratio may be reduced. In the British Army, with troops all over the world, the ratio is 4.2 per 1000, but this they admit is too low. Whatever the ratio, the government has first choice, on the basis of physical fitness, and private practice must do with what is left. Men, tin, oil and rubber are subject to priorities and are rationed out, but doctors, dentists and veterinarians are given the privilege of applying for commissions. No other group has such consideration.

4. At the present time our armed forces are disposed to by-pass graduates of unapproved medical schools, aliens, cultists, doctors with criminal records, women physicians, those over 44 years of age and the physically unfit.

What about standards of physical fitness? Before Pearl Harbor, draftees had to pass rigid tests. Three molars had to oppose three molars and three incisors had to oppose three incisors. Now selectees really ought to have upper and lower gums. Many doctors who volunteered and were rejected for physical reasons, will be passed when they come up before draft and induction boards. When the need for doctors becomes urgent enough, standards of physical fitness will almost disappear. Al-

ready this attitude has developed—"Suppose he is color blind, suppose he has but one eye, suppose he has a spot of T. B.—if he can practice medicine at home, he can practice medicine for the federal government, maybe not in the Army but somewhere."

And what about dependents? They are no problem for commissioned line officers. The government figures that salaries of commissioned officers, including doctors, dentists and veterinarians, will take care of dependents. The schedule of pay and allowances for Army officers is as follows:

RANK	Base Pay	DEPENDENTS		NO DEPENDENTS		TOTAL	
		Rent	Subsistence	Rent	Subsistence	Dependents	No Dependents
Colonel . . . . .	\$333.33	\$120	\$36	\$80	\$18	\$489.33	\$431.33
Lieutenant Colonel . . . . .	291.67	120	54	80	18	465.67	389.67
Major . . . . .	250.00	100	54	80	18	404.00	348.00
Captain . . . . .	200.00	80	54	60	18	334.00	278.00
First Lieutenant . . . . .	166.66	60	54	40	18	280.66	224.66

A 10 per cent increase has been added to the salaries of men serving in foreign lands.

Before deciding whether to volunteer for a commission or wait for the draft, many want to know how many doctors will be needed. "Will there not be enough without me? How long will it be before I am absolutely needed?"

Those are questions difficult to answer. We know that Congress authorized a Navy personnel of 500,000 and a Marine Corps of 104,000. How near we are to these quotas is a military secret. We know that at the outbreak of hostilities there were 1800 doctors allotted to the Navy and the Marines. Two thousand two hundred more are now or shortly will be needed. On Jap Sunday, there were 11,500 doctors in our Army of 1,700,000 men. There should have been 12,938 doctors but we were short 1438. A questionnaire was published in the Journal of the American Medical Association and 25,000 M.D.'s up to 85 years of age volunteered. The shortage was made up quickly out of the younger of these volunteers. But what about doctors for the expanding Army? How rapidly will the Army expand? How large will it be? It will expand just as fast as recruits from Selective Service can be trained. We assume that if training soldiers takes a year and if there are cantonments enough to train 2,000,000 men, the Army will demand 13,333 additional doctors in 1942. But there are just about that many in the Medical Bank. The Bank at present contains 13,000 residents and interns who are serving more than one year. Eighty per cent of metropolitan hospitals had intern services longer than one year, but now only one intern year is permitted. Research workers will be deferred only if the research concerns our war effort.

Applicants for diplomas in the specialties will work two years and the National Boards will give credit for military service for the rest of the work. While it now appears that 13,000 more doctors will be needed in 1942, this figure is subject to variables. Will the government be content with present facilities or will more camps be built? The President of the U. S. spoke recently of an Army of 8,000,000 men. Such an Army would require 61,538 doctors. In the whole of the United States there are only 62,000 physicians under 45 years of age regardless of physical fitness.

In addition we must obtain medical officers for the Navy, Marine Corps, Public Health, Medical School faculties, Veterans Bureau, Internal Revenue and Civilian Defense. What is the machinery for obtaining all this medical personnel? Procurement and Assignment has been established under the office of Defense Health and Welfare Service. Its functions are (1) to receive from various government and other agencies requests for medical, dental and veterinarian personnel; (2) to secure and maintain lists of professional personnel available showing detailed qualifications of such personnel, and (3) to utilize all suitable means to stimulate voluntary enrollment, having due regard for the overall public health needs of the nation, including those of governmental agencies and civilian institutions. Paul V. McNutt, present director, is exceedingly sympathetic toward the medical profession. His Executive Officer is Major Sam F. Seeley, a young regular Army officer who served his internship in the Walter Reed Hospital under Dr. Norman Scott. Major Seeley is 39 years of age; a member of the A. M. A. and F.A.C.S. and a graduate of the University of Minnesota. He is alert and on the job. He has about him a Directing Board headed by Dr. Frank Lahey of the Lahey Clinic in Boston and President of the A. M. A. This board prepared a statement which was published in the Journal of the A. M. A. February 21, 1942. They also have prepared a questionnaire which will be sent to every doctor in the U. S. The punch-card index of the A. M. A. already has a lot of data covering every one of the 155,000 physicians of this country—age, date of grad-

uation, school, specialty, if any, and whether certified or not. These data have been loaned to the government. When the new questionnaires are returned, the government will know whether you are married or single, number of dependents, physical fitness or at least your own ideas about your health and whether you regard yourself as essential to civilian needs. If 1000 x-ray men are needed, who are under 45 years of age and who are associated with Class A hospitals, Dr. Leland will turn a crank and out will come their cards.

Specialists will be graded as follows: 1. Top-flight professors. 2. Associates and assistants. 3. Other holders of certificates from the National Boards. 4. Younger men who still do general practice, but who are part-time specialists. As men are taken into the Army, they will be given rank according to their grouping. However, there will be disappointments in the Army's use of specialists. In civilian life 35 per cent of the practice of medicine is done by specialists, but in the Army only 10 per cent. It is inevitable, therefore, that some specialists, even some that are certified, will be assigned work for which they were not specifically trained. At this time roentgenologists, pathologists and psychiatrists are in greatest demand.

Finally, the new questionnaire will ask if you are ready to contribute your war effort and whether you prefer Army, Navy, Public Health or Civilian Defense practice.

Procurement and Assignment is aimed to prevent as many dislocations as possible, particularly in defense areas. There will be more doctors taken from metropolitan areas than from the wheat belt. More will be withdrawn from resorts than from defense production zones. To be specific, Atlantic City will supply more doctors proportionately than Camden and Ocean City more than Wilmington.

Although base hospital units have been and are being taken from medical colleges, Class A schools must be protected so that the annual supply of 6,000 graduates will not only flow as usual but actually will be accelerated. Of the 76 medical schools in the United States, only three have declined to go along with federal acceleration. Students of the Universities of Arkansas, Nebraska and Rochester may have difficulty in being deferred by their draft boards if 16 months of their four years are spent on vacations.

Procurement and Assignment was organized October 31, 1941, by the President of the United States. It consists of the following:

1. A National Directing Board. Chairman, Frank Lahey, M.D. With him are James Paul-

lin, M.D., Harvey Stone, M.D., Harold Diehl, M.D., Willard Camalier, D.D.S., and Major Sam F. Seeley, Executive Officer.

2. Nine Army Corps Area Committees. Delaware, New Jersey and New York make up the Second Corps Area. This committee is composed of Arthur Booth, M.D., Elmira, N. Y., Chairman of the Board of Trustees of the A. M. A.; Col. Samuel Kopetsky, M.D., President of the State Medical Society of New York, and former speaker of the House of Delegates of the A. M. A.; and William J. Carrington, M.D., of Atlantic City.

3. The New Jersey State Chairman is Charles Schlichter, M.D., of Elizabeth. With him are Harold Corbusier, M.D., of Plainfield; LeRoy Wood, M.D., of Newark, and D. B. Allman, M.D., of Atlantic City.

Representatives of the State Committee have been appointed in each county. They operate under federal assignment and are not appointed by the county medical societies. The Preparedness Committee of The Medical Society of New Jersey and its county representatives already have classified every doctor in this state. You are listed already as dispensible or indispensable at home. Hospitals are asked to list the members of their staffs who are indispensable. The new questionnaire may make changes in P. and A.'s list, but all those men who regard themselves as essential are not so regarded by Procurement and Assignment. For example, a young doctor in a neighboring county considered himself as indispensable because he had 30 obstetric cases booked for the year. Procurement and Assignment did not allow his claim and he's in the Army now. The criterion of availability for commission is based on the ability of the community to spare the individual and the status changes from time to time. For example, if there are two x-ray men in a community of 60,000, neither is indispensable until the other goes away.

How will all this Procurement and Assignment machinery work? If the armed forces of the United States need orthopedic surgeons, the punch card of John Doe, M.D., may come out. But John Doe is the only orthopedic surgeon near the Hercules Powder Plant of Dover, N. J. The P. and A. representative in Morris County will recommend to Dr. Schlichter, State Chairman, that John Doe be kept at home. If this meets the approval of the State, Corps Area and the National Committees, John Doe, M.D., stays at home.

At the present time, P. and A. is interested in the 62,000 M.D.'s of draft age. The Army needs First Lieutenants and Captains. It has plenty of Majors and Colonels. The older



men, particularly World War veterans, have volunteered in larger numbers than the younger men. But the Army will call few of these and most of them will be taken in as specialists. General practitioners under 35 years of age probably will be assigned to field forces rather than to hospital staffs, and rotation between field service and hospital work is unlikely. Men who are physically unfit for heavy Army duty will be assigned along with alien physicians to one of the other federal or civilian services, such as the coal mines of West Virginia, the wheat belt of the Dakotas, or the munitions plant yet to be built at Belcoville.

When the questionnaire arrives, you will fill it out, refuse to fill it out or wait a while. I hope that every member of the medical profession mails his reply the day it is received regardless of age, health or dependents. How you answer the question, "Are you ready to go?", is a question that each individual must decide for himself, but there is no possible escape from some kind of service. The government would only have to make examples of a few cases to break up any effort to shirk responsibilities. If you refuse to sign or put it off, which amounts to the same thing, you will be caught in the draft and your local board may send you into the Army as a private. If you are under 45 years of age, your number will come up before July, 1942. If you are between 45 and 55, your capsule will be drawn after July. The present Selective Service Act affects men up to 55. But there is nothing to prevent the Congress from extending the age limit. It has been done once already and will be done again if necessary. If you are drafted

before you have a chance to fill out the questionnaire, appeal and telephone Procurement and Assignment, 31 Clinton Street, Newark, New Jersey, and ask for Dr. Norman Scott. Physicians, dentists, and veterinarians who enroll with P. and A. will be given certificates indicating that they have made themselves available and will be privileged to wear insignia that such enrollment has been made. Some draft boards apparently never have heard of P. and A. but that is being corrected. Your appeal will have the backing of General Hershey, Selective Service and Procurement and Assignment.

If you have had an opportunity to sign up with P. and A. and fail to do so or procrastinate, you not only lose what chance of choice there is but the unfortunate impression may get about that you are trying to evade service. After observing Draft Boards at work for a year, I noted that if there was even the appearance of draft dodging, selective service boards, no matter how fair they tried to be, gave the draftee an extra shove toward Fort Dix. I would not be surprised to see this same psychological reaction in Procurement and Assignment.

If you have a notice of acceptance from P. and A. Service and present such notice to your draft board, you will have no trouble in being deferred to await active duty as a commissioned officer. No physician with an M.D. degree, licensed to practice in any state, will be inducted. He will be assigned, according to his physical capacity, to one of the federal services, industrial work or to a civil assignment, in the capacity of a medical officer.

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## CONSULTANTS IN MEDICAL AND DRUG SUPPLIES

Robert P. Fischelis, B.Sc., Phar.D., Chief Chemist of the New Jersey Board of Pharmacy, member of the New Jersey Board of Health, has been released from those duties in order to give part-time service as Chief of the Section of Medical and Health Supplies of the Civilian Supply Division of the War Production Board in Washington. Dr. Fischelis will

organize a staff of consultants and specialists in hospital, medical and drug supplies. Their function will be to study civilian needs and plan for the allocation of health and medical supplies; also the problem of replacing drugs derived from scarce materials with drugs of similar therapeutic action derived from more plentiful sources.

## 176TH ANNUAL MEETING

On April 21, 22 and 23, 1942, at Haddon Hall, Atlantic City, will be held the Annual Meeting of The Medical Society of New Jersey. This meeting may afford the last opportunity we shall all have *for the duration* to get together for a few days of fellowship, frivolity and fun, as well as to increase our store of professional knowledge and to learn what may be expected of us as professional contributors towards the winning of the war. Let

us take full advantage of this meeting. Come early and stay with us for Auld Lang Syne. There will be enjoyable social features, strong professional stimuli and a demonstration that we subscribe to the motto "E Pluribus Unum", professionally as well as nationally. Bring along your colleagues from your County Society and we shall have a good-natured rivalry in winning the honor of having the best attendance (percentage) among the component county societies.

## PRELIMINARY PROGRAM

### 176th Annual Meeting of The Medical Society of New Jersey

APRIL 21-23, 1942—HADDON HALL, ATLANTIC CITY, N. J.

#### SCHEDULE OF EVENTS

##### Monday, April 20, 1942

- 8:00 p. m.—Meeting of Board of Trustees
- 8:30 p. m.—Meeting of Judicial Councilors

##### Tuesday, April 21, 1942

- 11:00 a. m.—Meeting of House of Delegates
- 1:00 p. m.—Meeting of Woman's Auxiliary
- 2:00 p. m.—General Medical Session—"Medicine in War Time"
- 4:00 p. m.—Rolling Chair Ride for Auxiliary members
- 8:00 p. m.—Meetings of Reference Committees
- 8:30 p. m.—Nominating Committee Meeting

##### Wednesday, April 22, 1942

- 9:30 a. m.—Meeting of Woman's Auxiliary
- 10:00 a. m.—Section Meetings:
  - Radiology
  - Medicine
  - Surgical
  - Gastro-Enterology

- Eye, Ear, Nose and Throat
- Pediatrics
- Obstetrics and Gynecology

- 12:30 p. m.—Meeting of House of Delegates—Election
- 1:00 p. m.—Woman's Auxiliary Luncheon
- 2:00 p. m.—General Surgical Session—"Surgery in War Time"
- 2:30 p. m.—Meeting of Woman's Auxiliary
- 4:00 p. m.—Art and Hobby Exhibit Tea
- 7:30 p. m.—President's Banquet
- 10:30 p. m.—President's Ball

##### Thursday, April 23, 1942

- 10:00 a. m.—Meeting of House of Delegates
- 10:30 a. m.—Meeting of Woman's Auxiliary

#### EXHIBITS

- Art, Hobby and Medical History Exhibit
- Commercial Exhibit
- Scientific Motion Picture Theatre
- Scientific Exhibit

## THE MEDICAL SOCIETY OF NEW JERSEY

176TH ANNUAL MEETING

### DINNER-DANCE RESERVATION

Haddon Hall, April 22nd, 1942

\$3.00 per Person

Mrs. David B. Allman

104 St. Charles Place, Atlantic City, N. J.

Please reserve.....places in my name for the Dinner-Dance on April 22nd, 1942. My check for \$.....is enclosed.

Reservations will be valid only when accompanied by a check. Tickets will be ready for delivery at the Reservation Table in the Exhibit Hall of Haddon Hall.

Name .....

City .....

## GASTROSCOPY AND THE GENERAL PRACTITIONER \*

### A FIRST-YEAR REVIEW AT THE MOUNTAINSIDE HOSPITAL

By THEODORE S. HEINEKEN, M.D., Bloomfield, N. J.  
Read at the Staff Conference of the Mountainside Hospital, October 21, 1941.

A sword swallower was the first experimental subject for gastroscopy. This was in 1868 when Kussmaul tried to see directly into the stomach with a rigid periscope-like structure. The distance from mouth to stomach was so great that with the primitive illuminating devices then available, Kussmaul was unable to throw enough light on the stomach to make gastroscopy practical. With the introduction of the cytoscope, a new principal (electric light at tip, powered by wires running through the scope) was suggested, and on this basis in 1879, Nitze and Leiter set up an instrument in which a platinum wire loop running through the scope was supposed to provide illumination. Unfortunately it gave more heat than light.

Mikulicz, in 1881, suggested the correct methods for overcoming the difficulties, pointing out that the axis of the stomach forms a rather marked angle with the axis of the esophagus; that the lower pole of the stomach turns toward the anterior abdominal wall; that the greater curvature does not descend vertically but that the plane of the stomach is twisted and curved in a complicated manner. The instrument Mikulicz built was constructed with an angle of thirty degrees between the distal third of the instrument and the proximal two-thirds. He realized the possibilities of the gastroscope in clarifying the uncertainties in many digestive diseases.

Kelling, in 1897, was the first to recognize that a firm optical system was necessary; he otherwise followed the teaching of Mikulicz.

In 1907, Chevalier Jackson tried to develop a gastroscope from an esophagoscope, with simple open tubes such as Kussmaul had used. Such tubes are still important in the extraction of foreign bodies.

In 1908, Loenug and Steeda constructed a tube which gave satisfactory results, and in

1911, Elsner developed a gastroscope, while Sussmann made excellent contributions to the optical theory of gastroscopy.

#### THE MODERN GASTROSCOPE

In 1920, Rudolph Schindler first began to use Elsner's gastroscope and made observations of great importance. Many improvements were made and finally in 1932 the Wolf-Schindler gastroscope was developed. It was flexible with an optical system which was easily introduced, and most of the stomach could be seen clearly through it. Since Dr. Schindler has been in the United States, the Cameron-Schindler gastroscope<sup>1</sup> has been developed. The flexible scope is 77 centimeters long and with a maximum diameter of 12 millimeters. It is made with a 45-degree angle which gives excellent vision, with increased magnification. Its success depends on:

1. High degree of safety.
2. Causes only slight discomfort.
3. Allows good visualization of most of the stomach.

#### INDICATIONS

The indications for gastroscopy may be summarized as follows:

1. Unexplained symptoms like pain, indigestion, weight loss, hemorrhage, anorexia in any patient.
2. After roentgen demonstration of gastric lesions.
3. In "chronic dyspepsia" in all patients.
4. At onset of digestive symptoms in all patients over 35.
5. As a "follow-up" guide to the success of therapy in (a) healing of ulcer, (b) response to treatment in pernicious anemia and (c) after gastric surgery.
6. As part of a thorough clinical investigation.

\* From the gastro-intestinal clinic of the Mountainside Hospital, Montclair, N. J.

1. Schindler, Rudolph: *Gastroscopy*. University of Chicago Press. 1937.



### CONTRA-INDICATIONS

Contra-indications may be summarized as follows:

1. Uncoöperative patients.
2. Aneurysm of the aorta or mediastinal tumor.
3. Varices of the esophagus.
4. Obstruction of the esophagus or cardia.
5. Corrosive gastritis (chemicals).
6. Abdominal rigidity or fever in abdominal disorders.
7. Cardiac complications.
8. Marked scoliosis, kyphosis or arthritis.
9. Untreated jaundice.

### THE GASTROSCOPIC FIELD

The clarity of the view of the stomach through the gastroscope is remarkable. Erosions, pigment spots and small hemorrhages are seen distinctly. The normal mucous membrane presents a glistening, bright orange-red picture. Beyond the angulus, the antrum and pylorus come into view. The pylorus can be seen opening and closing; by rotating and slowly withdrawing the instrument, the remainder of the stomach and fornix can be seen. Gastric ulcer presents a grayish white or yellow floor and sharp edge, usually with a red inflamed area around the ulcer. The surrounding mucous membrane may be normal or may appear swollen, edematous and hyperemic, denoting an accompanying gastritis. Malignant ulcers present a different picture: the floor is dark brown or violet, the edge is ragged and irregular, the surrounding mucous membrane appears rigid, infiltrated and often grayish or white rather than orange-red.

Gastroscopy, however, is not a competitor of the x-ray. The employment of both should result in more frequent diagnosis of early gastric cancer. Operative intervention for early gastric carcinoma frequently results in a cure of long duration.

### CASE REPORT

Mrs. H. is 65 years old. Her complaints are: Indigestion, anorexia, epigastric distress (off and on for the past three months not relieved by medication), slight loss of weight, very little fatigue. Past history reveals a hysterectomy, and later appendectomy and removal of ovarian cyst.

*Physical examination:* This is a well-nourished, 65-year-old female. Nose and throat negative; except for auricular fibrillation, the chest is clear. In the abdomen we find slight tenderness in the mid-line above the umbilicus; no masses are palpable; no glandular enlargement is found. Blood pressure is 160/100. Hemoglobin is 74 per cent; R.B.C. 4,150,000; W.B.C. 4,500; Polys 40 per cent; lymphocytes are 58 per cent and monocytes 2 per cent.

*Urine:* Occasional trace of albumen.

*Stools:* Occult blood.

*Gastric analysis:* No free hydrochloric acid.

*X-rays:* Irregularity of the pyloric end of stomach with gastric retention at four hours and slight retention at twenty-four hours.

*Electrocardiograph:* Auricular fibrillation and mild myocarditis.

*Gastroscopic Examination:* Intravenous anesthesia was administered by Dr. Roseman. A ragged irregular ulceration is seen at the pyloric end of stomach with a brownish color to the base about the size of a dime. The surrounding mucous membrane seems stiff-like and paler than normal, with diminished size in the folds.

*Diagnosis:* Cancer at the pyloric end of the stomach.

*Operation:* On June 10, 1941, Dr. Frank Scudder performed a sub-total gastric resection. Exploration of stomach revealed a mass which originated in the prepyloric region but extended into the pylorus itself. A gastric resection was done, removing half to two-thirds of the stomach. The duodenal stump was closed over with two layers of fine atraumatic chronic and suture line covered over by suturing the duodenum to the pancreas. The upper half of the cut surfaces of the stomach was closed over with two layers of atraumatic chronic and the jejunum, just beyond the ligament of Treitz, anastomosed to the lower half of the opening in the stomach. No glands were palpable except for two or three small ones at the pylorus.

*Pathologic report* (by Dr. M. Fein): Infiltrating ulcerating adenocarcinoma of the stomach (grade II, Radio resistant).

*Follow-up:* This patient made an uneventful recovery and has been followed since operation every two weeks. At present she is well but has not gained in weight. She is much stronger and has no complaints.

### CHRONIC GASTRITIS

Chronic gastritis is a common disease of the stomach and is the greatest field of usefulness for the gastroscope. For many years this diagnosis was viewed with skepticism. The question has been settled by the gastroscope and the gastritis is now classified as acute, superficial, chronic, hypertrophic, atrophic or post-operative gastritis.

In superficial or catarrhal gastritis, the mucous membrane is redder and is adherent to the rugae and found between the folds. There

are small red hyperemic areas and, occasionally, small erosions.

In chronic hypertrophic gastritis the rugae are more pronounced and stiffer than normal. The mucous membrane is velvet-like, swollen and contains a number of nodules often referred to as "cobble-stoning". The membrane often contains hemorrhages and erosions, nodules or large nodes, creases and crevasses. The course is typified by failure of the mucosae to revert to normal. The gastritis may recur suddenly while the patient is under careful medical management.

In atrophic gastritis the mucous membrane is gray-green and the course of the blood vessels may be traced. The gastric wall is smooth and the membrane thin. In two cases we have noticed a mixed variety of gastritis in which patches of hypertrophy were associated with atrophy.

The etiology of post-operative gastritis is obscure. Schindler<sup>2</sup> found this complication absent in patients in whom a rhythmically functioning gastro-enterostomy stoma was present. In patients with a patent stoma the constant reflux of intestinal juices may cause and maintain the inflammation.

In the observation of ten post-operative stomachs seen at Mountainside Hospital, the patients who had had gastric resection showed milder post-operative gastritis than those following a gastro-enterostomy. This observation on so few cases may be only a coincidence, and further follow-up will be necessary to verify these conclusions.

#### GASTROSCOPY AT MOUNTAINSIDE

On September 17, 1940, the first gastroscopic examination was done at the Mountainside Hospital. Since then fifty such examinations have been performed. Following is analysis of the findings in this series compared with the distribution reported by Schindler<sup>3</sup>:

	Our Series	Schindler's Series
7 normal stomachs .....	14%	22 %
1 purpuric lesion .....	2%	6 %
9 gastric ulcers .....	18%	9 %
18 chronic, non-specific gastritis ..	36%	42 %
2 carcinoma of the stomach ...	4%	8 %
1 lymphoblastoma .....	2%	0.1%
1 diverticulum .....	2%	0.3%
10 post-operative stomachs .....	20%	8 %
1 unsatisfactory examination ..	2%	3 %

#### COMMENT

In one case (A. H.), the patient had been in the hospital under observation many times without relief of her nausea and vomiting. Atrophic gastritis was found and liver therapy started. At present this patient is free of her nausea and vomiting.

Four cases of atrophic gastritis were found and three of these show definite therapeutic improvement.

Seven normal stomachs were observed. One of these patients was later operated upon and found to have cholecystitis with adhesions.

The nine gastric ulcer cases have either showed improvement on follow-up or have come to operation with improvement and recovery after operation.

The two cases of gastric carcinoma include the one already mentioned. In the other, the gastroscope was just barely able to be placed in the cardiac end of the stomach where a diffuse carcinoma was observed. This was confirmed by operation a few days later.

The patient with lymphoblastoma had a history of gastric hemorrhage with a large mass in the epigastrium. There was some doubt as to the diagnosis by x-ray. Gastroscopic examination in May showed that the mucous membrane in the antrum was thick and dark-red; the stomach was distorted with a large amount of swelling. Pylorus was not seen. Protruding from the posterior surface were numerous polypi and on the anterior surface was denudation of mucous membrane with small red nodular protruding masses. This area was pale grayish and stiff-like; supporting hemispherical elevations of different sizes.

The diagnosis of infiltrating polypoid carcinoma was made. In view of the fact that diffuse lymphatic sarcoma of the body may

2. Schindler: Diagnostic Gastroscopy with Special Reference to the Flexible Gastroscope. J. A. M. A., 105:352, Aug. 3, 1935.

3. Cited by Flexner, J., and Fleishman, A.: Jour. D. O., Vol. VII, Aug. 1940, No. 8.

be hard to differentiate, I suggested x-ray therapy. Following this she improved. Report of her condition today shows she is still alive and has had only one gastric hemorrhage since x-ray treatment.

In the one unsatisfactory case (A. J.), the gastroscope was not passed. It was impossible to pass the Ewald tube because of an obstruction in the esophagus. Later the cardiac clinic found an aortic aneurysm.

On August 26th the patient (A. J.) had the gastroscope passed on him successfully and chronic hemorrhagic gastritis was plainly seen.

17 Park Place

## CONCLUSIONS

The visualization of the gastric mucosa with the aid of the flexible gastroscope is no longer a dreaded ordeal. If the patient is uncoöperative and nervous, the use of intravenous anesthesia (Pentothal Sodium), as outlined by Heineken and Roseman,<sup>4</sup> can be used.

This method makes it possible to obtain valuable information as to the presence, the character and extent of a gastric lesion. Inflammatory changes of the gastric mucosa can be demonstrated where other methods fail.

## VITAMIN TREATMENT OF FIBROSITIS

Fibrositis is defined as an inflammatory reaction of fibrous connective tissue. The pathologic picture found in fibrositis and that described as occurring in ducklings on a deficient vitamin E diet are practically alike. Fibrositis may occur as a primary disease or as a secondary disease. Internists are familiar with the muscle pain, swelling and pain associated with arthritis or gout. They have seen painful bursae associated with many rheumatic diseases. Very few, however, are familiar with the disease as a primary one. Many common diseases are in fact evidences of primary fibrositis but masquerade under various titles. These are variously diagnosed as lumbago, torticollis, muscular rheumatism, tendinitis, periarticular fibrositis, panniculitis, myositis, and so on.

Wheat germ oil was given in doses ranging from 2 to 8 cc. to 82 patients. Thirty cases of primary fibrositis were treated with vitamin E

in doses of 2 to 8 cc. daily and all were completely relieved of all symptoms. Twenty cases of atrophic arthritis with secondary fibrositis were given 2 to 8 cc. of wheat germ daily over a period of 2 to 4 months. Eight noticed definite improvement in muscle soreness and stiffness. Eight patients diagnosed as psychoneurotics ("psychosomatic rheumatism") were given wheat germ oil over a period of 2 to 3 months without relief. These were all later relieved by the giving of barbiturates or bromides.

It is suggested that vitamin E is of value in the treatment of primary fibrositis. Some of the more severe cases may require the more concentrated preparation of vitamin E to obtain a complete result. Vitamin E is of little value in the treatment of secondary fibrositis. These studies tend to indicate that primary fibrositis may be a metabolic rather than an infectious process.—C. L. Steinberg, *Am. J. Med. Science*. (Clif. Abstracts, 1941.)

## AMERICAN COLLEGE OF SURGEONS — APPROVED HOSPITALS

At its Boston meeting last month, the American College of Surgeons announced a list of 216 hospitals approved by the College for graduate training in surgery. The College has also published a manual of graduate training for the guidance of hospitals and surgeons. Only five hospitals in New Jersey are on their approved list. These are: The Cooper Hos-

pital in Camden, the Jersey City Medical Center and the Margaret Hague Maternity Hospital in Jersey City, the Burlington County Hospital in Mt. Holly, and the Newark City Hospital in Newark.

4. Heineken, T., and Roseman, H.: Review of Gastro-Enterology, 9:13-15, Jan.-Feb. 1942.



## TRAUMATIC RUPTURE OF A HYDROCELE WITH REPORT OF A CASE

By HUGH F. COOK, M.D., and GEORGE F. HEWSON, M.D., Newark, N. J.

A hydrocele is formed by an abnormal collection of fluid in the tunica vaginalis or in some part of the processus vaginalis which has not become obliterated. The most common hydrocele is that which forms in the lower part of the tunica vaginalis where the processus vaginalis has been obliterated. The other varieties of hydroceles will not be discussed in this paper.

### ACUTE HYDROCELE

Vaginal hydroceles may be either acute or chronic. Acute forms occur as a complication of an acute epididymo-orchitis or as the result of trauma. Acute hydroceles usually resolve on conservative treatment although suppuration, if it occurs, will necessitate drainage of the tunica vaginalis.

### CHRONIC HYDROCELE

Chronic forms may be either primary or secondary. Secondary forms are usually complications of tuberculosis, syphilis or malignant disease, and treatment is directed to the primary condition although diagnosis may have to be made by tapping. The primary form, which is more common, is that in which no direct cause can be determined. Some authorities believe that this is the result of a chronic genital infection in which the rate of production of the fluid is in excess of the absorption. The fluid is straw-colored, having a specific gravity of about 1.025; it does not clot, but contains albumin and occasionally cholesterol crystals. In long-standing cases thickening of the tunica vaginalis causes the production of atrophy of the testis.

### SYMPTOMS OF RUPTURE

An intact hydrocele gives few symptoms except for mechanical interference and a sense of weight. But when rupture of the tunica vaginalis takes place there are conspicuous symptoms and signs and it was the observation

of a case that prompted us to review the literature on the subject.

This is a rare accident. Collins<sup>1</sup> reviewed the literature in 1930 and reported sixty-three cases, including three of his own, with most of them recorded in France and Switzerland.

Rupture of the tunica vaginalis causes sudden and severe pain. Shock may occur. The scrotum becomes larger and softer. Discoloration from effused blood is generally seen within twenty-four hours of the rupture. According to Collins,<sup>1</sup> the edema generally begins to subside within a week if the case is untreated. The absorption of the fluid is accompanied by slight fever and malaise. Although complications are rare, cases of gangrene and even fatal septicemia have been reported.

To cause a rupture, the trauma need not be severe. Burdet and Delore<sup>2</sup> find that there is always a softening and degeneration of the tunica vaginalis and its coverings. Hence, a slight knock or blow may result in a rupture. St. Martin<sup>3</sup> has suggested that the rupture was caused by finger-like diverticulae of the tunica vaginalis which pierce the cremasteric fascia. Delore<sup>2</sup> considered degeneration of the tunica vaginalis as the cause.

### REPORT OF CASE

On January 2, one of us was called to see a patient (J. B., age 53) at 11 p.m. He gave the following history:

For the past two and a half years he had a gradually increasing swelling of the left side of his scrotum which did not produce much discomfort at rest but which caused some difficulty when walking. He had used a suspensory with relief.

At 10:30 p.m. on January 2 he sat down to unlace his shoes and inadvertently put his full weight on his scrotum. He felt a momentary sharp, tearing pain in his scrotum and noted that the former tense swelling, white in color, now presented a boggy, soft mass with a mottled appearance.

Physical examination revealed an obese male with

1. Collins, Joseph D.: Traumatic Rupture of the Tunica Vaginalis. *Southern Medical Journal*, 23:247 (March 1930).  
2. Cited by Collins, reference 1.  
3. Cited by Collins, reference 1.

the facies of one in some distress, sitting on the edge of the bed. He had no dyspnea or cyanosis. He was well oriented and coöperative. Temperature was 98.6 degrees and his pulse was 90. The scrotum was about twelve inches in diameter and the penis was not visualized although a small, puckered indentation suggested its presence. The skin overlying the enlargement was cyanosed and palpation revealed a boggy compressible swelling—distinctly not the tense swelling present in the normal hydrocele. The swelling was not tender although dull pain was present.

Percussion of the chest revealed an enlargement of the heart to the left, and there was an apical systolic murmur over the entire precordium. The heart rhythm was regular, blood pressure 180/87.

#### TREATMENT

A diagnosis of ruptured hydrocele was made and the patient was sent to the Presbyterian Hospital, Newark, where an aspiration of the scrotum was done with a trocar. About 500 c.c. of a bloody non-clotting fluid was removed. Following this the patient felt more comfortable.

Two days later, under ethylene anaesthesia,

a vertical incision was made over the scrotum and the layers dissected back revealing a tear about six inches long, involving all the fascial layers and containing many blood clots. The greater part of the parietal layer of the tunica vaginalis was resected and a modified Andrews operation was done. Two Penrose drains were inserted deep in the tissues. The skin was closed with plain catgut and reinforced with silkworm gut sutures.

#### RESULTS

Except for a mild pulmonary complication his post-operative course was uneventful and the drain was removed from the scrotum on the fifth day. Following this there was drainage of a serosanguineous fluid for six days. The wound healed by first intention and the scrotum contracted to normal size.

The patient has been followed up for eighteen months after operation and there has been no tendency toward recurrence.

21 Roseville Avenue

## URETHRAL ANOMALIES

Urethral diverticula and cul-de-sacs are anomalies of development and by no means as rare as authorities would lead us to believe. They give rise to no inconvenience under normal conditions and are only accidentally discovered while examining the urethra for other affections, reports Noah E. Aronstam in a recent issue of *The Journal of the Michigan State Medical Society*.

Two forms exist: (1) The diverticulum—a short, linear, narrow, collapsible pocket opening into the urethra, and (2) the cul-de-sac proper—a larger, longer and more distended pouch, stopping abruptly, or rather terminating blindly into the submucosa of the urethra.

When these became the seat of inflammatory processes, they may prove annoying and rebellious to treatment. They produce vague symptoms, simulating a mild case of urethritis and

may prove the cause of a prolonged urethral discharge. Should they become implicated in a Neisserian process, they may serve as starting points of stricture formation, particularly that of the longitudinal type.

Treatment is simple. The urethroscope is of paramount aid. With the latter in situ, the lacunar folds may be slit open with a small knife or urethrotome. Local anesthesia usually suffices. This must immediately be followed by insertion of sounds in ascending sizes, until the largest can comfortably pass the distal end of the lacunae and left in situ 10 minutes each time. This must be repeated several times in order to prevent the too premature closure or healing of the divided edges. The lateral bands ultimately atrophy at a level of the urethral mucosa, which may readily be ascertained urethroscopically.

## CIRCULATION TIME AND VENOUS PRESSURE

By EDWARD C. KLEIN, JR., M.D., Newark, N. J.

Read Dec. 3, 1941, before the Fourth Annual Fall Clinical Conference of The Medical Society of New Jersey at Elizabeth.

The speed of blood flow changes continuously as it makes its circuit. This alteration in blood velocity is determined primarily by the principle that the speed of a fluid column varies inversely with its cross section. Although direct measurements of blood velocity have been devised for animals by Burton-Opitz<sup>1</sup> and others, technical difficulties do not permit similar experiments in humans. Therefore, as a clinical measure of the velocity of blood flow in man, we use the "Circulation Time".

## TECHNIQUE

Circulation time is the time necessary for the blood to pass from one arbitrary point in the vascular system to another. Usually, material is injected into the antecubital vein of the subject and we then time the arrival of a sensation elsewhere in the body. This interval is the "Circulation Time". The most frequently used substances are *decholin* and *saccharin*. The latter was first used by Fishberg, Hitzig and King<sup>2</sup> in determining the arm-to-tongue circulation time. Two and a half grams of saccharin are dissolved in 2 cc. of sterile water by heating. This solution is then cooled and injected rapidly into the antecubital vein. A sweet taste heralds the arrival of the saccharin at the tongue.

*Decholin* (Sodium Dehydrocholate) was introduced by Winternitz, Deutsch and Bruell.<sup>3</sup> Five cc. of a 20 per cent solution are introduced into the antecubital vein; its end point is a bitter taste.

By these methods, the arm-to-tongue circulation time in health is found to be 8 to 16 seconds. It represents the time required for the fastest particle of blood to flow from the antecubital vein via the superior vena cava, the right heart, the pulmonary circuit, the left heart, and the arterial tree to the tongue.

Weiss, Robb and Blumgart<sup>4</sup> have injected a 1:10,000 solution of *histamin phosphate* into the vein. The arrival of the histamin in the minute blood vessels of the face results in a flushing of the face and a peculiar metallic taste in the mouth. This arm-to-face circulation time averages 24 seconds in health.

Robb and Weiss<sup>5</sup> have employed a 2 per cent aqueous solution of *sodium cyanid*. The signal reaction is a sudden deepening of respiration due to stimulation of the carotid sinus by the drug. In normal subjects, this arm-to-carotid sinus time varies between 9 and 21 seconds.

Of all these methods, the simplest is probably the saccharin time because it is so economical. Its major disadvantage is that the threshold of sweetness varies with many people, resulting in a fluctuant end point. Fleeting pain in the arm may occur but is never dangerous. Venous thrombosis has been reported, but I have never seen one.

Decholin with its bitter taste has a much sharper end point and would be preferred except that it is more expensive. Histamin is dangerous in that it often produces severe dyspnea in patients with circulatory failure. It may be followed by violent headache. Sodium cyanid produces an uncomfortable and often a burning substernal distress.

In performing the test, have the patient reclining as nearly flat as comfortable. The arm is supported on a pillow so that the vein is approximately level with the heart (about 5 cm. below the level of the fourth costo-sternal junction). After inserting the needle, remove the tourniquet and wait a moment for readjustment of circulation and tourniquet application. Then inject the solution rapidly. The time elapsing between the moment of injection to the moment of taste perception is recorded with a stop-watch. This measures the time required for the fastest particle of blood to travel from the arm, through the right heart,

1. Burton-Opitz: Am. Jour. Physiol., 7:435 (1902).  
2. Fishberg, Hitzig and King: Proc. Soc. Exp. Biol. and Med., 30:651 (1933).  
3. Winternitz, Deutsch and Bruell: Med. Klin., 27:986 (1931) and 28:831 (1933).

4. Weiss, Robb and Blumgart: Am. Heart Jour., 4:1 (1939).  
5. Robb and Weiss: Am. Heart Jour., 8:650 (1932-1933).



the lungs, and the left heart to the tongue or head. Obstruction along any of these pathways will increase the circulation time.

By the use of *ether*, Hitzig<sup>6</sup> has developed a method of measuring the arm-to-lung circulation time. Five drops of ether mixed with an equal amount of saline are injected into the arm vein. The time elapsing until the ether vapor is tasted by the subject and smelled by the observer is noted. This represents the circulation time between the antecubital vein and the capillaries of the lung, which, normally, varies between 4 and 8 seconds. In health, the ether time is about one-half the saccharin time. In heart failure, this relationship may be disturbed and yield information as to the type of failure; i. e., whether in the right heart or in the left heart.

#### PRACTICAL VALUE

The practical value of determining the circulation time is its great aid to the clinician in the differential diagnosis of heart failure. The test is so simple a procedure that it requires no laboratory nor any equipment other than a syringe. The procedure can be carried out as efficiently in the home or office as in the hospital.

The circulation time is prolonged in most patients with symptoms due to heart failure. If failure is limited to the left side of the heart, there will be a prolonged saccharin time but a normal ether time, showing that the failure is limited to retardation of blood flow through the pulmonary circuit in the venous half (capillaries to the left side of the heart). This occurs only at an early stage of failure of the left side of the heart. Increasing back pressure along the venous half of the pulmonary circuit from the failing left ventricle results in more marked engorgement. Ultimately, this is transmitted to the arterial half of the lesser circuit and then the ether time is prolonged as well. The hypertension produced in the lesser circulation is an important factor in the pathogenesis of dyspnea in left heart failure. When the right heart weakens, pressure in the pulmonary circuit falls with relief

of dyspnea and orthopnea. The circulation time is further prolonged, however, by the addition of right-sided failure to the preëxistent left heart failure; i. e. both saccharin time and ether time are prolonged with resultant greatly increased circulation time. Left ventricular failure leads to prolonged arm-to-tongue time, while right ventricular failure increases the arm-to-lung time.

In dyspnea due to obesity, bronchial asthma, compression of the trachea or bronchi by aneurysm or mediastinal tumor, the circulation time is normal. In pneumonia, pneumothorax or emphysema uncomplicated with heart failure, the circulation time is normal.

In the presence of pitting edema, circulation time is prolonged only if due to right heart failure. Edema of renal origin and ascites of hepatic cause yield a normal circulation time.

In thyrotoxicosis, circulation time is very short, whereas, in contrast, myxedema yields a prolonged reading. Fever and anemia may accelerate circulation time and thus tend to mask slight degrees of heart failure.

The circulation time in shock has been little studied and needs further investigation. In the shock of coronary thrombosis, Fishberg<sup>7</sup> found little or no prolongation of arm-to-tongue time. Similar observations were made in post-operative shock. These experiments imply that impairment of circulation in shock is due mostly to decrease in the circulation blood volume, whereas the small quantity of blood in the vessels circulates at almost the usual speed.

#### VENOUS PRESSURE

That venous engorgement often enables the detection of an insufficient heart at first glance has been familiar to clinicians for centuries. In fact, Stephen Hales,<sup>8</sup> in 1769, measured the venous pressure in the horse and sheep by inserting a glass tube into the jugular vein and observing the height to which the blood rises, a method still in use today. A non-instrumental method for venous pressure determination is employed by Lewis.<sup>9</sup> He considers the external jugular vein as a manometer extending into the

7. Fishberg, Hitzig and King: Arch. Int. Med., 54:997 (1934).

8. Hales: Statical Essays (London) (1769).

9. Lewis: Brit. Med. Jour., 1:849 (1930).

6. Hitzig: Proc. Soc. Biol. and Med., 31:935 (1934) and Am. Heart Jour., 10:1080 (1935).

right auricle. The height at which the blood distends the vein is observed. In health, this is at the level of the upper portion of the manubrium in the sitting posture, and on reclining, at the junction of the upper and middle thirds of the neck. However, obesity and anomalous anatomic variations often render observation of these cervical veins difficult or even impossible. In elderly people the existence of phlebosclerosis may give apparent distension with normal venous pressure.

For the more accurate and instrumental determination of venous pressure, the method employed by Taylor, Thomas and Schleiter<sup>10</sup> is most satisfactory. An L-tube of 4 mm. bore is used, the tip of the short limb being ground to fit an intravenous needle, while the long limb is graduated in centimeters. After the saccharin time is completed, replace the syringe with the L-tube, keeping the needle intact in the vein. Keep the arm at the level of the right auricle. The blood rises in the tube and is read off directly in centimeters. With this method, the venous pressure in normal individuals is between 4 and 8 cm.

Determination of venous pressure enables the physician to ascertain whether circulatory failure is due to cardiac weakness or to peripheral circulatory failure.

Insufficiency of the right side of the heart is the common cause of elevated venous pressure—normally over 15 cm. Factors, other than right heart failure, responsible for elevated venous pressure are mechanical compression of the great veins by mediastinal masses, adhesive pericarditis or venous thrombosis (especially vena cava). In shock, systemic venous pressure is characteristically depressed.

With relatively slight insufficiency of the right heart in which the antecubital venous pressure is within the limits of normal, the right-sided insufficiency can often be demonstrated by engorgement of the jugular veins and a rise in antecubital venous pressure that follows compression of the abdomen in the right upper quadrant—the hepato-jugular reflux. This is, likewise, an excellent clinical method for the differential diagnosis of hepatic enlargement.

The practical lesson all this serves is to give rapid valuable knowledge in the differentiation between failure of the heart and factors which may simulate cardiac symptoms; to differentiate between types of heart failure; and to distinguish between heart failure and peripheral circulatory collapse. Simple tests, they are easily performed and furnish added aids to our medical armamentarium.

209 Littleton Avenue

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## APOPLEXY AND LOW BLOOD PRESSURE

Three fatal cases are presented in which the blood pressure was being recorded hourly following operation, and in which cerebral vascular accidents occurred at a low point of a gradual drop in blood pressure. Death ensued, 1, 10 and 5 days, respectively, after the stroke. Necropsy revealed widespread areas of partly hemorrhagic necrosis in the cerebral cortex with little involvement of the subjacent white matter.

These cases are of significance primarily be-

cause they demonstrate the clinical onset of so-called apoplectic strokes in elderly men, coincident with a *drop* in blood pressure. It may prove to be worthwhile in such cases with progressive drop in blood pressure to treat not only the threatened state of shock by temporarily lowering the head and other usual methods but also the possible beginning thrombosis by administration of anticoagulants such as heparin. In addition, Cobb has recommended the use of cerebral vasodilator drugs, the best being carbon dioxide.—A. D. Ecker and M. Deren. *Am. Jour. Med. Sc. (Clinical Abstracts, 1941)*

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10. Taylor, Thomas and Schleiter: *Proc. Soc. Exp. Biol. and Med.*, 27:867 (1930).

## THE PLACEMENT OF CARDIOVASCULAR CASES IN INDUSTRY\*

By MAX GREENBERG, M.D., Linden, N. J.

American Cyanamid Company

Most heart disorders are found in men of advancing years. These are the men who are the most valuable to an industrial plant, and to whom industry should feel the greatest responsibility. The young man comes into an industry fresh and able-bodied; but he does not remain that way. He becomes time-worn, and work-worn. He also becomes more loyal, more efficient, stronger in character—in short, a person who is increasingly valuable to the plant. The problem of how to deal with the loyal, experienced worker who has become a health hazard is a difficult one that has assumed great importance. There was a time when it was customary to discharge the man who gave evidences of oncoming heart disease. But today this is considered socially inhuman and industrially wasteful and expensive. We think we can find better ways which will preserve the job for the man, and which will, as well, make it profitable to the plant. I want to explain how we try to solve this problem.

First, we endeavor to discover the cardiovascular patients early, that is before the onset of dramatic episodes. How is this done? The most important phase of this work is carried out in the examining room of the plant. Each incoming worker is routinely studied. This means a complete physical examination including a urine analysis, blood count, chest x-ray and the two-step cardiac test. This is our measuring stick, our point of departure. A patient whose examination reveals no suspicious signs is released for work—but not forgotten.

Should the examination yield any signs suggestive of heart disease, three-way x-rays are taken and an electrocardiogram is done. Incidentally electrocardiograms are routinely taken on all men over the age of 40. All workers in the plant are periodically reexamined, and patients in whom suspicious signs are present are frequently reexamined and electrocardiographed.

### THE ELECTROCARDIOGRAM

The electrocardiogram is useful in "watching" heart cases by repeated graphs. Even normal hearts often reveal one or more so-called abnormal waves. This has no significance so long as the graph shows no alterations in future tracings. As soon as changes in the pattern are detectable, the physician must be on the alert for oncoming, or even already existing early stages of heart damage. This is the very time to treat the patient and to make the necessary work adjustments.

We take the functional capacity of the heart into consideration as well as the anatomic diagnoses. The electrocardiogram is used not only as a diagnostic instrument, but also for measuring functional capacity. An electrocardiographic change before and after the two-step test gives us fair indication of cardiac function. The diagnostic tests tell us where the damage is,—a geographic location so to speak. The functional test establishes the degree or amount of damage—a quantitative test.

### SOURCES OF INFORMATION

The examining room is the first place to search for signs of heart diseases. The physician who is anxious to avoid severe episodes, however, must go out frequently and watch the men at work—particularly those of forty and over who have yielded the faintest suspicious signs. Every manifest physical evidence takes on significance in these cases. Unusual pallor, undue weakness, weariness and the like are ominous signals for the alert doctor. Sometimes ill temper or irritability is the sign that all is not well. Breakage, forgetfulness, etc., must be noted. These can be seen upon direct observation, or gathered indirectly from the remarks of other workers. This procedure is not a form of espionage. It is intended only and absolutely as a helpful practice and it operates in this way.

Certain other sources of information yield insight into the possible presence of early heart

\* Read December 3, 1941, before the Clinical Conference of The Medical Society of New Jersey.



disease. These are the family history, the patient's medical history, his own remarks about how he feels, how he felt after some competitive event and so on.

Using all the medical and psychologic instruments of diagnosis, we find those men who are likely to become heart cases, or those who already have it in the early forms. Of course at times we discover advanced cases too.

The next problem is to do something about it.

It is the policy of this department to keep loyal and valuable men at work as long as possible and at the most suitable occupation.

First we recognize the cases as early as possible, because early recognition often means a prolongation of healthy and useful life. Then we classify and place our cardiovascular cases so as to keep them at work within the limits of their functional capacity.

While it is possible to classify a man according to the diagnostic findings, this is contrary to the basic principle we are trying to bring out. Instead, we classify our heart cases and place them in work positions according to the functional capacities of their hearts. Of course, we can not lose sight of the nature of the heart disease nor the extent of the pathology. For while the work classification does not depend on pathology, it is perhaps modified by it; and treatment, regrouping and prognosis greatly depend on it.

The systems of classifications available for application in cardiovascular cases are the *functional* and the *therapeutic*—as suggested by the American Heart Association. These are "work test" classifications and they group men according to the functional capacities of the heart. Examine the subdivisions of each of these tests, and you will see how they differ.

#### FUNCTIONAL CLASSIFICATION

The Functional Capacity Classification reads:

1. Patients with cardiac disease and no limitation of physical activity. Ordinary physical activity does not cause discomfort. Patients in this class do not have symptoms of cardiac insufficiency, nor do they experience anginal pain.

2. Patients with cardiac disease and slight limitation of physical activity. They are comfortable at rest. If ordinary physical activity is undertaken,

discomfort results in the form of undue fatigue, palpitation, dyspnea or anginal pain.

3. Patients with cardiac disease and marked limitation of physical activity. They are comfortable at rest. Discomfort in the form of undue fatigue, palpitation, dyspnea or anginal pain is caused by less than ordinary activity.

4. Patients with cardiac disease who are unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, are present, even at rest. If any physical activity is undertaken discomfort is increased.

This tells the limits of the functions of the heart. There is no margin of safety left.

#### THERAPEUTIC CLASSIFICATION

The Therapeutic Test reads:

A. Patients with cardiac disease whose physical activity need not be restricted.

B. Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against unusually severe or competitive efforts.

C. Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous habitual efforts should be discontinued.

D. Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

E. Patients with cardiac disease who should be at complete rest, confined to bed or chair.

It can be seen that the "Functional Classification" measures the limit of the cardiac reserve. The Therapeutic Classification places the patient within the limit of reserve. If we were to place a patient according to the "Functional Test" and let him work to the limit of his capacity, there would be eventual damage to the myocardium. We prefer a margin of safety allowed by the therapeutic classification and determine a man's work with this in mind. Furthermore, the amount of work allowed with this test also serves as a therapeutic measure.

#### ANATOMIC CLASSIFICATION

Having classified a patient, however, the task is not complete. We also keep the anatomic picture and classification in mind. The classification used is that set forth by the American Medical Association, with the following large pathologic groups:

1. Disease of the pericardium.
2. Diseases of the myocardium.

3. Diseases of the endocardium and valves.
4. Rheumatic heart disease.
5. Diseases of the aorta and pulmonary artery.
6. Syphilitic heart disease.
7. Diseases of the coronary arteries.
8. Congenital anomalies of the heart and coronary vessels.
9. The conduction system.

#### APPLICATION OF CLASSIFICATION

This is how it applies in practice. Let us suppose a man has presented suspicious signs during an examination, and was further studied by electrocardiogram, x-rays, etc., and was placed in a certain group in the functional and therapeutic scale. That does not complete the picture. A pathologic diagnosis must be added to arrive at a true status. For example: three men, one having a rheumatic heart and another having a syphilitic aortitis, a third having benign hypertension, may all, at the time of examination, be placed into the same therapeutic group on the basis of a functional determination. But the rate of negative progress will be very different for each of these cases. The hypertensive may remain a long time in each therapeutic group, the others will probably pass rapidly from one to the other on the descending scale and each in slightly different ratio. We find it fruitful, indeed essential, to establish a clear pathologic picture and to determine as well the therapeutic group where the patient belongs.

#### CORONARY OCCLUSION

One of the forms of heart disease that has given industry a great deal of ground for thought is coronary occlusion. It is often ushered in with an attack that has caused plant management to become panicky. That is—coronary occlusion, when it occurs in a plant, looks dramatic and is consequently very disturbing. Current opinion, based on outdated rather than advanced knowledge, made plant management feel that a man who has had a coronary attack was “through”.

All recent medical investigations on the nature and treatment of coronary occlusion seem to agree on certain basic viewpoints, however much they disagree on emphasis and detail. It is now known that coronary occlusion will come when it does without regard to the physi-

cal activity or inactivity of the body. As Master, Dack and Jaffee<sup>1</sup> say: “\* \* \* certain data make the conclusion inescapable that activity is of no importance in the precipitation of coronary occlusion”. The period of day and actual hour when occlusions occur play no rôle. In fact, the peak hours for coronary attacks are from 10 p. m. to 2 a. m. when most people are resting or sleeping. (See Table No. 1.)

TABLE NO. 1  
MASTER'S HOUR OCCURRENCE CHART<sup>1</sup>

#### TIME OF ONSET OF CORONARY ARTERY OCCLUSION IN 470 ATTACKS

Hour	No.	Hour	No.
1 A. M. ....	23	1 P. M. ....	23
2 ..... 37		2 ..... 19	
3 ..... 19		3 ..... 17	
4 ..... 11		4 ..... 14	
5 ..... 15		5 ..... 15	
6 ..... 19		6 ..... 20	
<hr/>		<hr/>	
122 (26%)		108 (23%)	
7 A. M. ....	23	7 P. M. ....	16
8 ..... 18		8 ..... 15	
9 ..... 20		9 ..... 16	
10 ..... 19		10 ..... 30	
11 ..... 23		11 ..... 25	
12 ..... 18		12 ..... 18	
<hr/>		<hr/>	
121 (26%)		120 (25%)	

Hence, we are justified in anticipating that the coronary occlusion will not take place in the plant. It will probably occur in the patient's home, perhaps in bed. We are moreover justified in the assumption that the kind of work a man does is not responsible for a coronary attack, and the plant management should have no hesitation in permitting men of 40 or over to go on working. Men of 40 or over are mentioned because it is this group which is most susceptible to attack.

Although the seizure comes without regard to activity and usually not during work, this does not relieve the plant physician from responsibility in these cases; on the contrary, even the most sudden seizures—sudden at the acute moment—usually present premonitory warnings. And the plant physician who is eager to minimize complications of coronary attacks, and to reduce their possible occurrence

1. Master, Dack and Jaffee: American Heart Journ., 18:4:434 (Oct. 1939).

within the plant, must look for a varying symptomology.

Besides the usual anginal syndrome in about half of the cases, a protean symptomatology may represent the premonitory complaints. Sometimes nothing but extreme weakness if the symptom; sometimes symptoms relate to the gastro-intestinal tract.<sup>2</sup> In one of our cases the coronary attack was preceded by the usual premonitory warnings of an anginal syndrome, anguish and dyspnea; in a second, the symptoms were purely gastro-intestinal; and in a third, the only warning was general weakness.

The management of coronary disease is of the utmost importance. All that we have tried to do about heart cases in general applies specifically to coronaries, but in these, placement and management, rather than early detection, is the important issue. We have already suggested that a careful examination will sometimes reveal possible heart limitations. This cannot be easily foretold in instances of coronary occlusion. When a young man in good health is examined, there is no way of telling that he may become a coronary risk at the age of 40 or later. What we can do has already been suggested. We can carefully observe the men over 40, or those who present suspicious signs, and try to recognize the premonitory warnings as soon as they occur.

Since coronary occlusion is no respecter of persons or professions, it occurs with all classes of people and people doing all kinds of work. (See Table 2.)

TABLE NO. 2

OCCUPATIONAL DISTRIBUTION OF 1039 CORONARY DISORDERS <sup>1</sup>		
Occupation	Number	Percentage
Workers and laborers . . . . .	377	36%
Store workers . . . . .	55	5%
"White collar" and office workers . .	90	9%
Business men . . . . .	114	11%
Professional men . . . . .	86	8%
Housewives . . . . .	221	21%
None, or retired . . . . .	96	9%

2. Reisman, David: "Cardiovascular Disease and Its Gastric Masquerades", Journ. Amer. Med. Ass'n, 91:152 (Nov. 17, 1928); and Parsonett, Aaron: "Manifestations in Cardiovascular Disease", Jour. Med. Soc. of N. J., 25:90 (Feb. 1928).

TABLE NO. 3

DISTRIBUTION OF OCCUPATIONS AMONG 722 PATIENTS WITH CORONARY OCCLUSION COMPARED WITH GENERAL POPULATION<sup>1</sup>

Occupations	Coronary Occlusion	U. S. Census N. Y. C., 1930
All occupations . . . . .	722	3,187,459
Workers and laborers	377 (52%)	1,766,458 (55%)
Store proprietors (retail), "white-collar" and office workers, business men . . . . .	266 (37%)	1,169,713 (37%)
Professional workers	79 (11%)	251,178 (8%)

Laborers are no more likely to succumb to coronary disease than anyone else (see Table 3). The great difference lies in our desire to do something about our men who have coronary attacks. The fact that many of them are laborers doing hard work makes the after-care problem an interesting one.

We go on the basic assumption that the coronary occlusion patient need not—indeed often should not—be invalidated for the rest of his life. A patient during an attack must, of course, be immediately treated. This is done by the family physician, who is often aided by our history of physical findings, x-rays, electrocardiograms, etc. We do not hasten the return of the patient to the plant. Physical incapacity may persist for weeks or even months. But when the attack is over we take the man back into the plant. Now we give him a thorough reëxamination and measure carefully the limits of his functional capacity. Then he is placed in the therapeutic group that is safe and suitable for him. It is our experience that men who have had coronary attacks and have recovered from them and are then placed safely within their work limits can work on for many years without any incidents. In fact, according to Katz,<sup>3</sup> their span of life and usefulness need not be impaired. These are of course older men, and as such we watch them at their work, and we regroup them whenever necessary. Sometimes only a little ingenuity is required to change a man's job

3. Katz, Louis: "Electrocardiography", 1941, Lea & Febiger, p. 158.



from an active to a physically inactive one, and yet keep him working and profitable to the plant organization. We had such a case with a pipefitter, a splendid worker who suffered a coronary attack. Upon recovery he was placed in the same department laying out the work rather than executing it—thus safely within his therapeutic margin and performing a highly skillful and useful operation.

#### COMMENT

It will no doubt seem revolutionary, perhaps even foolhardy to some, to take back men who have had coronary disease. But it is not foolhardy at all; it is human and reasonably safe. All our coronary patients are back at the job, seem to enjoy good health and perform their

work efficiently. Their loyalty has increased manifold. Compare this with another branch of medicine. Many doctors recall the time when a mentally sick person was judged insane, incurable and hopeless. That time has passed and the change is accepted. It seems to me that the coronary occlusion cases were stigmatized too, often in a similar way. We have felt here that these men are worth saving for the jobs which they needed—and for the plant which needed them. Our experience so far as been fortunate. Before any strong assertions can be made, however, we will need to go on working with coronary cases in this manner, collecting evidence and data. This we are in the process of doing, and we hope that in time we will have more statistical evidence.

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### SULFONAMIDS IN PUERPERAL SEPSIS

It is recommended that chemotherapy be employed in puerperal sepsis only when the disease is severe and then after the responsible organism has been identified and shown to be of a type susceptible to action of the drug. It is further recommended that blood transfusion

be recognized as an effective treatment for puerperal infections and that it be given consideration even when chemotherapy is employed.—A. W. Diggle and W. F. Mengert. J. Iowa Med. Soc. (Clin. Abst., 1941.)

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### A LESSON FROM A DEATH CERTIFICATE

#### NUMBER THIRTY-NINE

Patient examined at home to see whether she was in labor. Did not use proper sterile precautions. She was sent to the hospital where she was in labor 20 hours and a cesarean was done. Patient became septic and died. How did she become septic?

With proper preventive prenatal care, the need for cesarean can usually be suspected before labor begins. When an examination is necessary strictest precautions should be used.

A. W. BINGHAM, M.D.

## RADIOLOGY IN OBSTETRICS

### MATERNAL WELFARE ARTICLE NUMBER SIXTY-EIGHT

By H. J. PERLBERG, M.D., F.A.C.P., Jersey City, N. J.

Read before the Fall Clinical Conference of The Medical Society of New Jersey, Elizabeth, N. J.,  
on December 3, 1941.

In obstetrics, as in other fields, the x-ray cannot take the place of clinical examination and sound clinical judgment; it does, however, supply the physician with more precise information about certain factors that influence the course and conduct of pregnancy and labor. At the Margaret Hague Maternity Hospital, since its opening in 1931, radiography has become an increasingly important and valuable part of their program. In addition to the usual routine radiographic work such as is done in any hospital, special methods are employed, peculiar to a maternity hospital. Some of these special procedures I shall describe briefly.

#### DIAGNOSIS OF PREGNANCY

With the perfection of certain laboratory tests, pregnancy can usually be diagnosed before the fetal parts are radiographically demonstrable. But there are cases in which diagnosis is confused, or in which associated pathologic conditions must be differentiated. Fetal parts are readily demonstrable by the fourth month of pregnancy, and at times, under proper conditions, may be demonstrated as early as the twelfth week.

#### FETAL PATHOLOGY

Fetal death is shown by overlapping of the cranial bones associated with the fact that the fetus has not increased in size, corresponding to the period of gestation, all this confirmed by the usual clinical manifestations. The radiographic examination establishes the differential diagnosis between pregnancy and hydatidiform mole, which is of special importance because the latter also gives a positive Ascheim-Zondek response. Radiology also makes it possible to differentiate between pregnancy and tumor, and to diagnose abdominal pregnancy. It shows the presence of multiple pregnancy, and the position and presentation of the fetus.

Radiologic examination also reveals fetal abnormalities, like hydrocephalus and anencephalic monsters. Another condition in which

diagnosis is aided by radiographic examination is placenta praevia. This may be shown radiologically with the aid of sodium iodide or air in the bladder, which visualizes any deviation from the normal in the relationship of the fetal presenting part and the bladder. Or, the position of the placenta may be quite definitely ascertained by means of soft tissue films.

#### PELVIC MEASUREMENTS

One of the chief uses of radiography in obstetrics is the evaluation of true pelvic measurements and the determination of any possible disproportion between the maternal pelvis and the fetal head. Roentgenologic pelvimetry has definite advantages over the older forms of pelvimetry; by special methods described below the true conjugate may be measured, and other pelvic dimensions determined. In addition, the shape of the pelvis, especially of the pelvic inlet, is clearly shown, as well as the position and size of the fetal head in relation to the maternal pelvis. All these factors have an important bearing on the mechanism and conduct of labor, and knowledge of them prior to the onset of labor is of inestimable value to the obstetrician.

Since the pelvis is "away from" the radiographic film, the film cannot be measured directly to give the true pelvic dimensions, as there is always disproportion. Several methods are available to compensate for this disproportion.

#### THOMS METHOD

One of these methods, which is simple, efficient and easily applied in any hospital or community with x-ray facilities, is that devised by Thoms of Yale. It does not require expensive or complicated equipment, and we have found it reasonably accurate. The procedure is to place the patient upon the table in a semi-reclining posture so that the plane of the pelvis is parallel with the plane of the table. The position of the promontory and of the sym-

physis and the distance of each from the table are noted; exposure is then made after which the patient is removed from the table. The Thoms grid (which is a sheet of lead in which holes are placed throughout its entire surface at a distance of one centimeter) is then placed on the table over the exposed film in the same relative position as the plane of the previously exposed pelvis. A flash exposure is made and the film is developed. The film then shows the pelvis, upon which are superimposed the holes in the grid. Since the grid and the pelvic plane have been in the same position, the disproportion is similar. The distance between pairs of dots may be considered as one centimeter each, and the dimensions are determined simply by counting the dots. This apparatus is relatively inexpensive. A complete outfit, comprising an arrangement with a backrest, which can be placed directly upon the table, and an appliance to fix the distance of the promontory and the sacrum from the plate, is put out by the University of Georgia at a cost of fifty dollars.

#### JOHNSON METHOD

Another technique is a method of stereoradiogenometry devised by Johnson of California. Stereoscopic films of the pelvis are made in antero-posterior position. They are then superimposed in a special view box in a horizontal position. Extending from one side of the view box is an upright to which are attached two reels of fine wire, to the ends of which are affixed a pair of compasses. Also extending from the upright are two adjustable brass rods. The points of the compasses are placed upon the same bony landmark of the pelvis and the place where the wires cross in air is marked with one of the rods. Another bony landmark is similarly located and the points of the brass rod are measured in air by a centimeter ruler. The conjugata vera and other dimensions are thus recorded. The procedures are highly technical, and the slightest variation in technique may distort the image so that improper measurements are then obtained. This method, however, has much merit.

#### CALDWELL-MOLLOY METHOD

The method which we have used for a number of years is that described by Caldwell and Molloy of Columbia University. Films are made by a standard technique. Stereoscopic antero-posterior films of the abdomen are taken with the patient in the supine position, centering on a line extending across the anterior superior spine, the stereoscopic shift being above and below this line. For this examination a soft lumbo-sacral pad is placed in the lumbar area to tilt the pelvis slightly downward. The outlet film, to show the subpubic arch, is made by shifting the tube downward toward the feet for a distance of thirteen inches, then inclining the tube upward forty-five degrees. For this examination the lumbo-sacral pad is removed, and the patient lies flat on her back with a pillow under her head. The lateral film is then made best with the patient upright, strapped against the plate changer with the central ray at the sacrosciatic notch. In this examination a special rule devised by our own department is employed. It consists of a hollow bakelite tube containing alternate segments of lead and bakelite each exactly one centimeter in length. The lower end is placed between the upper portion of the buttocks, and the upper end is fastened to the back directly over the spinous processes so that it is exactly parallel with the spine. The exposure is then made. Again we have the principle applied in the Thoms method, that is the disproportion between the centimeter markings in the rule is equivalent to that in the pelvis, since the mid section of the pelvis is exactly the same distance from the film as is the rule. By means of this rule we are then enabled to take various measurements, such as the true conjugate.

Stereoscopic films are measured in a special precision stereoscope devised by Caldwell and Molloy, by means of which an image of the true size of the pelvis is obtained, and measurements are made through this medium. These measurements are well corroborated clinically.

#### PELVIC TYPES

In the Caldwell and Molloy method, the types of pelvis as shown radiographically are given special consideration in considering the obstetric indications and prognosis.



There are four parent pelvic types, the gynecoid, android, anthropoid and platypelloid. The *gynecoid* pelvis is the typical female type and is characterized by the presence of a round inlet, showing very nearly equal hemispheres; this is usually associated with a broad or so-called Norman arch and a fairly wide sacrosciatic notch; the inclination of the sacrum is backward, with the sacral curve usually well marked.

The second, or *android* type, presents the greatest obstetric difficulties; the pelvic inlet is heart-shaped with a wide flattened posterior segment and a narrowing of the fore-pelvis, giving a triangular effect; there is usually a wide, deep subpubic arch with narrow intertuberous dimensions, a narrowed sacrosciatic notch and a forward inclination of the sacrum; there is usually a convergence of the side walls, giving the pelvic outlet a funnel shape which is frequently the cause of mid-pelvic arrest in labor.

The third type is the *anthropoid*, which is characterized by an increased longitudinal diameter of the pelvic inlet with a correspondingly narrowed transverse dimension; the posterior pelvis is rounded and the fore-pelvis is usually narrowed, the contour being kite-shaped; the sacrum is usually long and may contain six instead of the customary five segments, and it is inclined downward; the sacrosciatic notch is usually of medium width as is also the subpubic arch.

The fourth type is the *platypelloid*, the characteristic of which is an increased transverse dimension with a narrowed anteroposterior diameter, presenting an oval shape; the sacrum in this type of pelvis usually extends quite sharply backward giving a broad sacrosciatic notch; the width of the pubic rami is average to broad. Unless small, this type of pelvis does not offer an insurmountable obstacle to normal delivery provided the head presents in a transverse position, after which it may be rotated when in the true pelvis, since there is usually ample room.

There is also a fifth group, of rare occurrence, the *asymmetrical* pelvises. The asymmetry

may be due to a congenital anomaly or to disease, such as tuberculosis or poliomyelitis, which frequently causes a distortion of the pelvis, and, of course, there is the effect of injury. This group is *sui generis* and each case must be judged individually.

It would be very fine if we had only these four parent types of pelvis to deal with, with an occasional asymmetrical pelvis, but it is unusual to have a pelvis which is strictly one of these parent types. Most pelves partake of the characteristics of more than one parent type so that we have mixed forms. Originally Caldwell and Moloy used fourteen types, later reducing them to eleven, then to nine, and a year ago they reverted to the fourteen type classification. These types are classified according to the posterior segment and the variation of the anterior segment; for instance, a rounded posterior segment with a narrow fore-pelvis is classed as gynecoid-android, and so on through the various combinations. As there cannot be an anthropoid-platypelloid or a platypelloid-anthropoid type, there are fourteen rather than sixteen possible mixed types.

#### INTEGRATION OF FINDINGS

After the pelvic measurements are made and the pelvic type determined radiologically, and after other visualizable conditions of interest to the obstetrician have been noted, these observations must be considered in relation to the clinical findings in order to determine the obstetric prognosis. At the Margaret Hague Hospital, this is done in a staff conference, the final indications for the conduct of labor in each case depending upon the decision of the chief of the service in charge of the clinic. In the conduct of an obstetric case, it must be remembered that not all important factors are indicated by radiologic findings. Such disorders as uterine inertia, cervical stenosis, etc., are not visualized. However valuable the radiologic findings may be, nothing can take the place of the physician's physical examination and clinical judgment; but from our experience we are certain that the department of roentgenology serves as a valuable adjunct in any well-regulated obstetric hospital.

## STATE ACTIVITIES

### THE MODERN TREND TOWARD BETTER ORGANIZED MEDICAL SERVICES \*

By LEROY A. WILKES, M.D., Executive Officer, The Medical Society of New Jersey

Current events seem to prove the statement that "change is the only constant thing in life". A review of the changes that have taken place in the organization and activities of the medical profession in New Jersey since its inception in 1766 show that our own profession exemplifies this truth.

The reason for organizing the practitioners of medicine in New Jersey as announced in 1766 by the seventeen members who held their first meeting was "the low state of medicine in New Jersey and the many difficulties and discouragements attendant thereon". After the decision to organize was reached, the kind of organization came under discussion, and it was felt by some that an approach should be immediately made to the Legislature for a legal recognition and charter. Others felt, however, that this would involve necessarily certain laymen's assistance, and that it might be better, for a while at least, to have only doctors participate in this organization. It was therefore finally decided that the subscribers to the organization "would agree and form themselves into an amicable and brotherly society to be called and known by the name of The Medical Society of New Jersey". It is interesting to recall that New Jersey was, at this time, a colony of Great Britain, hence the name, which is the same as that under which this organization exists today.

The announced purposes of this brotherly society was "to enlarge our stock of knowledge and experience in the pursuit of this science". This was to be done through an interchange of suggestions between the more experienced and the less experienced practitioners. It was expected that social intercourse and other useful refinements might follow from the associations formed.

Realizing that all organizations must have rules to govern their members, they immediately set forth to provide what were called the "Instruments of Association and the Constitution of The New Jersey Medical Society". The great majority of these provisions dealt with

the purely scientific aspects of medical practice, and the ethics to be observed by the practitioners. The question of fees came very prominently to fore and was discussed at the very first meeting. A fee schedule was suggested, but it was not until 1784 that one was provided. According to the records, neither this nor any subsequent fee schedule have proven quite satisfactory. Certain principles were established, some of which have been maintained to this day. They resolved to distinguish sharply between the qualified and the unqualified practitioner, and between the deserving poor and the financially independent patient. The instruments did, however, clearly state that while they would take care of the distressed poor in their respective neighborhoods who had no legal support from their county; where legal provision is made for these distressed poor by the town or county to which they belonged, the doctors should look to the legally responsible agency for a reasonable remuneration.

Another interesting principle and policy established at the very first meeting was that they were to hold two meetings a year, and unless a member gave an adequate and satisfactory explanation for nonattendance, he would be fined three pounds. This was an early recognition of the need for effective disciplines in a well-organized effort.

It was recognized from the earliest beginning that changes would be necessary as a result of the experience gained by the members, and it was provided that such changes could be made. The procedure for making the changes was laid out. It was as early as 1768 that the Medical Society first petitioned the Legislature for the recognition later given in the charter.

This organization continued as a brotherly association without legal status until 1790, when an official charter and seal was granted by the Legislature, which thereby recognized The Medical Society of New Jersey members as the qualified practitioners of medicine. The Legislature and the public they represented evidently were satisfied with the conduct and

\* Read before the Essex County Medical Society, February 12, 1942.

ability of the members of the Medical Society following the granting of the charter, as is evidenced by the action of the Legislature in 1816 in granting a new charter broadening the responsibilities and privileges of The Medical Society of New Jersey, and officially looking to the Society as the proper group to approve and license their associates in the practice of medicine. In 1825, an additional right was granted to The Medical Society of New Jersey to grant the degree of M.D. to those whom they would regard as worthy successors in the practice of medicine to insure continuance of a high grade of medical service. The Society during these years, and for many years thereafter, although it grew in number and assumed many new responsibilities and obligations, was still concerned with the provision of a high quality of medical care provided by individually selected men of proper qualifications.

About this time, a reorganization plan to provide for more permanence and continuity was reached through the establishment of a Standing Committee which was primarily the executive body. Like the Trustees of our own day, they had large powers ad interim of the semiannual meetings. Many of you know the story of the expansion of organization and program of The Medical Society of New Jersey from here on—the establishment of the Board of Trustees, the development of the Welfare Committee, and the increasingly complex organization necessary to continue the enlarged work and to integrate and implement the expanding interests and activities of the medical men in their growing communities.

It was medical men who were among the first to realize the need for *health departments*; for the registration of vital statistics; the provision of mental hospitals; certified milk; protective health legislation; the provision and distribution of medical literature; and for the integration of the efforts of the medical profession into community health programs with those of other agencies having health implications, and needing our help.

Medicine is now being still more definitely organized for service, both within and without The Medical Society of New Jersey. Organization is much more readily effected from without The Medical Society of New Jersey, largely because we are, so far as organization for service goes, still a "Brotherly Society" whose officers are the servants of the component county societies and the individual men who pay the dues. Authority always lies with the source from which the funds come, and disciplinary power is inseparable from authority.

In public health departments and other offi-

cial agencies, the work is directed and done by selected personnel, engaged for their special experience in any of many lines. Funds and authority are provided by law which insures the discipline necessary in the scheduled discharge of the obligations undertaken. We too have more recently realized the need for this, and in our Medical Service Administration we are trying to work out a compromise on the provisions which we hope may effectively bridge this gap. The problem today is no longer primarily the provision of satisfactory professional services. It is essentially the success obtained in meeting a proper demand for use of these services. This demand is, in itself, an approval of the services offered to those who can afford to pay only in the most economic and effective way possible. Many believe that the introduction of the insurance principle in pre-payment for services which may be needed will provide a forward step toward this end. Some advocate an indemnity payment out of which services may be purchased.

Others prefer an installment payment for services received. Some few of course still expect to get something for nothing, and believe that medical service should be included in this category. Others believe that taxation is the only fair way to spread the costs among the people. All of these controversies merely indicate that people are not generally complaining of the quality of medical care furnished in America, but endorse it and believe that a wider and more economical distribution is both possible and desirable. Until recent years it has been largely those individuals who have intelligence and initiative to seek a doctor on their own initiative that have received the greatest benefits of medical care. Others may have been aware of their need for medical service, but through a lack of understanding of the generosity of the physician toward those unable to pay at any given time, have consciously neglected their needs.

Still another group has been driven by pain or other impelling forces to seek medical care in any way they could. Others do not care even when made aware of their needs. For many of these, hospitals have long provided outpatient departments in which doctors contribute their services and gain experience and recognition for themselves. Many such clinics, especially in university hospitals, have become teaching centers.

In recent years, greatly increased emphasis has been laid upon early diagnosis and on prevention. Large groups of assembled citizens have been periodically "screened" to detect early signs of defects or disease, in order to



get patients in touch with curative medical services as soon as possible. The development of what is known as Industrial Medicine has been, in about 15 per cent or more of the plants, one of the most effective and widespread means for the accomplishment of this purpose. It is to the interest of industry to have physically as well as mentally competent workers to produce. But it is also to the workers' benefit.

The public schools have a widespread provision for such screening services, but too often the quality has tended to decline, due primarily to an enormous overload at all times upon the doctor and in many cases the examination has become a mere gesture. It is to the interest of all schools that the child be physically and mentally fit to benefit most from the educational opportunities offered in them and many School Administrators know and act upon this fact.

The insurance companies have provided an examination of high quality in many cases, and it is also to their interest to see that early deviations from normal should receive the attention of medical men, because the objective of their examination is to estimate the longevity to be anticipated by the company for each individual examined to whom they could sell a policy, and this information is essential in such estimates. Industry, on the other hand, is interested chiefly in the present ability of the worker to do his job, whereas the schools are primarily interested in the ability of the pupil to profit continuously from the educational opportunities offered, chiefly in aural and visual form; and in the pupil's ability to get from his home to the school and back again. Physical examinations must have a clear-cut objective, such as "screening" or precise diagnosis and treatment, if they are to serve best the purpose for which they are devised and used. Treatment is distinctly an individual problem and is primarily the concern of the private practitioner and those in public hospitals or other institutions.

The war has brought sharply to our attention the need for large numbers of physicians in the armed forces, and more than ever before in the civilian population under modern war conditions. Our program of civilian defense now provides during wartime under Federal and State government control and direction, an organized system of protection against accidents and disease on a national scale. The full coöperation of the medical profession is needed, and many M.D.'s have assisted in the drawing of these plans, in the organization of the personnel, and in the actual operation in time of need as a war time activity. It is interesting to point out that

such an organization has been worked out by expert administrators. Such an organization could function here, as it has in Europe, also as a peace time governmental system. I hasten to assure you, however, that Dr. Fishbein has been assured by President Roosevelt and Mr. McNutt of Social Security Administration that the Civilian Defense program is regarded and intended solely as a war time activity, and that they have no intention or purpose in converting it into a system of permanent state medicine following the war. Winning the war is now our first concern and we must accept this assurance.

Two separate functions are concerned in organized medical effort. (1) One is strictly *professional*, and only a doctor and his allied workers can successfully operate this part. (2) The other is a business operation where special training and experience in the formulation and use of plans, ways and means, administrative set-up for cost accounting, budget making, executive supervision and control are needed to accomplish the single purpose of bringing together at the proper place and time the qualified doctor and the patient who is in need of his services at that time. There is no inherent conflict in these two services. Rather should one supplement the other to their mutual advantage. The doctor should be paid a fair reward for his services. The administrative staff should likewise be paid a fair reward for their services. Whether the form of payment be a fee, a per diem or monthly rate, or a yearly salary is of small consequence, because a just reward is the greatest incentive to better accomplishment. The private practitioner's patient may get better service because he pays the doctor directly than he would if he contributed through taxes to a national or state fund out of which a doctor would be paid by his government for services rendered by him, but the attending physician may also react unfavorably to the delayed or neglected payment by the patient. Organized effort is claimed to increase achievement by elimination of waste motion and time, and by insuring reward, but overload of work can defeat this economy. Adequate time and effort should be given to every individual case in need, and the physician should not be unduly restricted in organizations in the use of this needed time. There is today, however, a definite trend toward professional teamwork, and toward better organized effort in the *distribution* of medical care, and it may well also become evident that our organized efforts will provide the most effective defense of our individual professional liberties, to serve the public in the most effective way to the mutual satisfaction of patient and physician.

## ADVISORY COMMITTEE ON CHILD HEALTH

A meeting of the Advisory Committee on Child Health of The Medical Society of New Jersey was held at the Academy of Medicine, Newark, on January 7, with the Chairman, Dr. Chester Brown, presiding.

The question of special provisions to be considered in the problem of evacuating children from hospitals formed the theme of the meeting. It was the opinion of the Committee that the responsibility rested upon each hospital. It was thought advisable to send a letter to the Chief Pediatrician of the New Jersey hospitals, embodying certain recommendations for his consideration. A copy of these suggestions was sent to Dr. Charles Schlichter, Chief of Emergency Medical Services in Civil Defense, so that he might be aware of the recommendations of this Committee.

The subject of immunization of children was discussed with the idea of reaching agreement as to the best procedure to be recommended to state health departments and to the school authorities. In addition to diphtheria the recommendations will include the modern technique of immunizing against whooping cough and smallpox. The following recommendations

were accepted by the Committee with regard to diphtheria immunization:

1. Infants should be given their injections beginning at the ninth month and at least by the first year.
2. The Shick test should be done not less than four months after the last inoculation in order to discover those cases which have not been successfully immunized. It is suggested that the Shick test should be read on the sixth or seventh day after injection.
3. Alum Precipitated Toxoid should be given in 1 cc. doses, using two doses one month apart.
4. Plain toxoid should be given in 1 cc. doses, using three doses one month apart.

Other subjects discussed tentatively were the training courses for nurses in the care of prematurely born infants, the collection and study of data on the infant from the maternal record books in the New Jersey hospitals, the emphasis on a pediatric program at one of the meetings of the county medical societies, and the periodic contribution of subjects on child welfare to *The Journal of The Medical Society of New Jersey*.

ROBERT E. WRIGHT, M.D., Secretary,  
Committee on Child Health.

## ADVISORY COMMITTEE ON CONSERVATION OF VISION

The Advisory Committee on Conservation of Vision of The Medical Society of New Jersey met with representatives of the New Jersey Optometric Association at the request of the State Defense Council on January 28, 1942. Dr. Elbert S. Sherman acted as Chairman of the joint meeting.

Dr. Earl H. Ridgeway of the New Jersey Optometric Association presented a program of his organization for meeting the emergency. This program includes the following point:

Questionnaires have been received from optometrists giving information about their availability. Spot maps have been prepared showing the distribution of optometrists and ophthalmologists in New Jersey. Each optometrist volunteered his services at least one day a week to the war effort. They are available for refracting ambulance drivers, plane spotters, air raid wardens and draftees. They are prepared to help in screening out visually inefficient employees doing precision work in war industries and to assist in teaching first aid measures in eye accidents. Plans are now being reviewed for

emergency eye clinic units. Study is also being made for special optical apparatus for the visually handicapped who are otherwise physically able to serve in civilian and war industries.

A copy of the program was given to each member for individual study.

After the representatives of the Optometric Association had retired, the Advisory Committee held an executive session.

On motion, duly carried, the name of Dr. Solinger was added to the list of ophthalmologists for the New Jersey Commission for the Blind.

The Chairman announced that he felt that the reports of the number of children whose eyes were being examined by optometrists for school boards had been exaggerated. The Committee agreed that there was no need for immediate action on that matter.

JOSEPH H. KLER, M.D., Secretary,  
Advisory Committee on Conservation of Vision.

## STATE AND MUNICIPAL HEALTH OFFICIALS' ANNUAL MEETING

The annual meeting of the State and Municipal Health Officials was held at the State House in Trenton on February 6 and 7.

Dr. Charles H. Schlichter of Elizabeth, Chief of Emergency Medical Services in the New Jersey Defense Council, discussed the subject of "Health Departments and Defense". Dr. J. Lynn Mahaffey, State Health Director, spoke on "Health Problems and Progress in 1941", and Dennis J. Sullivan, Jersey City Chairman of the Executive Committee of the New Jersey Health Officers Association, discussed health progress from the viewpoint of the local official.

Dr. E. R. Coffey, Assistant Surgeon General of the United States Public Health Service, spoke on "Health Education" and discussed how the efforts of the various groups in the community and state can be integrated in a common purpose. Ralph T. Fisher of the

State Health Department continued a discussion of this paper.

"Industrial Health Problems" were discussed by Dr. J. Walter Hough and Dr. C. C. Pierce of the U. S. Public Health Service, and Dr. J. M. Carlisle, representing The Medical Society of New Jersey.

The subject of cancer control for New Jersey was outlined by Dr. Otto R. Holters of Asbury Park, representing The Medical Society of New Jersey, and Dr. Leonid S. Snegireff, of the State Health Department.

"Dental Progress" was the topic of Dr. J. M. Wisan of the State Health Department and L. Van D. Chandler, City Health Officer of Hackensack, New Jersey.

Dr. Harold W. Hager of Ocean City, retiring President of the Health Officers Association, gave the main address at the Annual Meeting of this Association held on Saturday, February 7.

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## ANNUAL MEETING OF THE SOCIETY OF SURGEONS OF NEW JERSEY

The meeting was held in Trenton on January 28, 1942. At the Mercer Hospital, before 25 guests, Dr. Frank G. Scammell performed a thyroidectomy and a gastro-enterostomy. Both of these cases were done under local anesthesia. Dr. Arthur M. Barrows performed a hysterectomy, also under local anesthesia.

At the St. Francis Hospital, before 36 guests, Dr. George N. J. Sommer performed a pan-hysterectomy and an amputation of breast with Bovie. Dr. Samuel Sica did a Caesarian section and also a prostatectomy. Dr. George D. Williams did a hysterectomy. Dr. Herman Cohen did an excision of pilonidal cyst and also excised an anal fissure. Tonsillectomies were done by Dr. Harry North and Dr. Wilbur Watts. Dr. Elmer Brown demonstrated teeth extraction and a rewiring of compound fracture of the jaw.

At the Eye Clinic of the Dispensary, Dr. A. H. Koplin demonstrated the treatment of an advanced case of vernal catarrh and corneal complications with electro-coagulation, also a case of ophthalmoplegic migraine and treatment of an advanced case of myasthenia gravis with prostigmin.

In the surgical laboratories, Dr. E. L. Shaffer demonstrated pathologic specimens of mediastinal tumor and associated goiter, a Krukenberg tumor of the ovary associated with carcinoma of the breast, and showed also

a very early specimen of carcinoma of the sigmoid colon. Dr. E. L. West demonstrated the treatment of impacted ureter calculi in De Propanax. Dr. P. J. Finegan exhibited orthopedic cases and Dr. Sica presented the end results following a Kraske operation. Dr. D. L. Haggerty discussed the use of sulfanilamide in the case of acute appendicitis.

Luncheon for 80 was served at the Trenton Country Club, after which the following movies of operations were shown through the courtesy of Davis & Geck, Inc.:

Skin grafting and the  $\frac{3}{4}$  thickness skin graft for prevention and correction of cicatricial formation. Dr. Earl C. Padgett, University of Kansas Hospitals.

Thyroidectomy for large adenomatous goiter including preoperative preparation and anesthesia. The Jackson Clinic, Madison, Wisconsin. Radical mastectomy for carcinoma, using a triangular axillary skin flap. Dr. Thomas G. Orr, University of Kansas Hospitals.

Subtotal gastrectomy for gastrojejunal ulcer. The Lahey Clinic, Boston.

Combined abdomino-perineal resection (one stage) for carcinoma of the rectum. Dr. Fred W. Rankin, Lexington, Kentucky.

Vaginal hysterectomy, clamp method for uterine prolapse. Price-Kennedy operation. Dr. Louis E. Phaneuf, Boston.



At the business meeting the following new officers were elected:

President—Dr. Charles H. deT. Shivers,  
Atlantic City

First Vice-President—Dr. Louis C. Lange,  
Weehawken

Second Vice-President—Dr. Elmer P.  
Weigel, Plainfield

Secretary—Dr. Walter B. Mount, Mont-  
clair

Treasurer—Dr. Christopher A. Brokaw,  
Elizabeth

Chairman of the Executive Committee—  
Dr. Edward W. Sprague, Newark

The following six surgeons were elected to  
Active Membership:

Raul R. Betancourt, M.D., M.Sc., F.A.C.S.,  
Camden

William D. Crecca, M.D., F.A.C.S., Newark

John J. Flanagan, M.D., Newark

Walter F. Phelan, M.D., F.A.C.S., Eliza-  
beth

John J. Quinn, M.D., F.A.C.S., Jersey City

Edward F. Uzzell, M.D., F.A.C.S., Atlantic  
City

The Spring Meeting will be held on May  
27, 1942, in Montclair, and the Annual Meet-  
ing will be held on January 27, 1943, in At-  
lantic City.

The members and their guests listened to  
an inspired talk on "The Problems of the  
Medical Schools During the Emergency", by  
Father Alphonse M. Schwitalla, S.J., A.B.,  
A.M., Ph.D., LL.D., ScD., Professor of Biol-  
ogy and Director, Department of Biology, St.  
Louis University, Dean of St. Louis Univer-  
sity School of Medicine, Past President of the  
Catholic Hospital Association of the United  
States and Canada.

## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physi-  
cian who publishes an article outside the state,  
notify the Editorial Office in Trenton, giving  
the title of the paper and the name of the  
periodical, as well as the month, date, volume  
and page number. It would also be helpful to  
this office if members would notify us of  
articles published by their colleagues.

Reprints of the article by Mildred V. Nay-  
lor, Librarian of the Academy of Medicine,  
may be obtained from the Academy Library,  
91 Lincoln Park, Newark.

The following list covers January, 1942:

BENJAMIN, Harold C. (Jersey City)

Traumatic bilateral separation of the lower fe-  
moral epiphyses. *J. Bone and Joint Surg.*, 24:200-  
201, Jan. 1942.

BINGHAM, Arthur W. (East Orange)

Statistics on other accidents of childbirth as a  
cause of maternal mortality in New Jersey. Ma-  
ternal Welfare article No. 66. *J. M. Soc. New  
Jersey*, 39:33-35, Jan. 1942.

CARPENTER, C. C. (Summit)

Safe method of applying solidified carbon dioxide.  
*J. A. M. A.*, 118:296, Jan. 24, 1942.

COSGROVE, S. A. (Jersey City)

Cesarean section. *J. A. M. A.*, 118:204-210, Jan. 17,  
1942.

D'ALESSANDRO, Arthur J. (Newark)

Heparin: its properties and clinical use; collec-  
tive review. S., G. and O. *Internat. Abst. Surg.*,  
74:62-69, Jan. 1942.

DINGE, Ferdinand C. (East Orange)

Differential diagnosis in peripheral vascular dis-  
ease. *J. M. Soc. New Jersey*, 39:30-32, Jan. 1942.

FERRARY, Paul B. (Totowa)

Erythremic response to liver therapy in treat-  
ment of pernicious anemia. *J. M. Soc. of New  
Jersey*, 39:19-20, Jan. 1942.

FINKLER, Rita S. (Newark)

Stilbestrol therapy in menopause. *Med. Woman's  
Jrl.*, No. 1, Vol. XLIX, Jan. 1942.

GERENDASY, Julius (Elizabeth)

Ano-rectal pain, its causes and treatment. *J. M.  
Soc. New Jersey*, 39:21-26, Jan. 1942.

GNASSI, A. M. (Jersey City)

Adenocarcinoma of the rectum and chromargen-  
taffine tumor of the jejunum. *Am. J. Surg.*,  
55:163-165, Jan. 1942.

HEINEKEN, Theodore S. (Bloomfield)

Use of pentothal sodium intravenous anesthesia  
for gastroscopic examination. *Rev. Gastroenterol.*,  
9:13-15, Jan.-Feb. 1942.

KAPLAN, J. Allen (Jersey City)

Traumatic bilateral separation of the lower fe-  
moral epiphyses. *J. Bone & Joint Surg.*, 24:200-201,  
Jan. 1942.

LATHAM, Ruth M. (Upper Montclair)

Spinal anesthesia with crystalline pontocaine  
hydrochloride: 467 consecutive administrations.  
*Anesth. & Analg.*, 21:34-40, Jan. 1942.

MARSH, Elias J. (Paterson)

An outline history of The Medical Society of N.  
J. to 1903. *Proceedings of the N. J. Historical  
Society*. Jan. 1942.

MOOLTEN, Sylvan E. (New Brunswick)

Duodenal ulcer following acute injury of the  
spinal cord. *Oppenheimer Anniversary volume.*  
*J. Mt. Sinai Hosp.*, 8:868-877, Jan.-Feb. 1942.

NAYLOR, Mildred V. (Newark)

Medical Librarian. *Bull. M. Library A.*, 30:124-25,  
Jan. 1942.

NEVIUS, William B. (East Orange)

Incidence of tuberculosis among 2562 high school students in a suburban city. *J. Pediat.*, 20:104-109, Jan. 1942.

NORTON, J. F. (Jersey City)

Cesarean section. *J. A. M. A.*, 118:204-210, Jan. 17, 1942.

PITKIN, George P. (Bergenfield)

Prolonged local or block anesthesia with regulated cell reception. *Anesth. & Analg.*, 21:1-12, Jan. 1942.

PRICE, H. P. (Jersey City)

Adenocarcinoma of the rectum and chromogentaffine tumor of the jejunum. *Am. J. Surg.*, 55:163-165, Jan. 1942.

ROSEMAN, Herman I. (Montclair)

Use of pentothal sodium intravenous anesthesia for gastroscopic examination. *Rev. Gastroenterol.*, 9:13-15, Jan.-Feb., 1942.

SOMMER, George N. J., Jr. (Trenton) and Robert C. Major (Atlanta, Georgia)

Neoplasms of the bony thoracic wall. *Ann. Surg.*, 115:51-83, Jan. 1942.

SPRAGUE, Seth B. (Jersey City)

Traumatic bilateral separation of the lower femoral epiphyses. *J. Bone & Joint Surg.*, 24:200-201, Jan. 1942.

TAYLOR, Robert (Jersey City)

Accessory apparatus to assist in proper posturing of the pelvic inlet. *Am. J. Obst. & Gynec.*, 43:140-143, Jan. 1942.

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## THE EYE-SIGHT OF THE WORKER

New Jersey has long been noted for the number and diversity of its manufacturing industries. Recently, because of the war, there has been a large expansion of both plant and personnel of those industries producing defense material. Along with this there has been a very large increase in the number of industrial accidents. In the metal working plants a large percentage of the resulting injuries are of the eye or adjacent tissues.

Five years ago this writer published some data concerning the ration of industrial eye accidents to the total number of accidents in seventeen plants engaged in various kinds of industry in the Newark area. (Greater New York Safety Council, 1937. The Worker's Eyesight, Session No. 31, paper No. 100.) Of 3215 total accidents, 1210 (37.6 per cent) were eye injuries. This is an abnormally high ratio

of eye accidents. About four per cent of them cause some permanent impairment of vision. These and other well-known facts definitely indicate the need for intensifying accident prevention work in industry. Today when our vast armament program is putting a great strain on many industrial plants, and the loss of time caused by preventable accidents is so important, the publication of the 300-page study entitled "Eye Hazards in Industry" by the late Louis Resnick (Columbia University Press) and sponsored by the National Society for the Prevention of Blindness, is particularly timely. (Mr. Resnick's book was reviewed on page 125 of the February Journal.)

ELBERT S. SHERMAN, Chairman,  
Advisory Committee on Conservation of Vision.

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## ANNUAL MEETING OF NEW JERSEY FELLOWS OF THE AMERICAN ACADEMY OF PEDIATRICS

At the Essex House in Newark on February 18, thirty-nine members of the American Academy of Pediatrics who reside in New Jersey, met and held their Annual Meeting. Several guests were present and were introduced by their host. The State Chairman for New Jersey, Dr. LeRoy A. Wilkes, presided as toastmaster, and the guests were entertained by Joseph Fries, M.D., a pediatrician attached to several of the Brooklyn, New York, hospitals, who presented "Thirty Minutes of Magic". The interesting part of Dr. Fries' contribution was the fact that his avocation of magic has been of inestimable value to Dr. Fries as a pediatrician. "Magic" intrigues the interest of

groups of children and wins their coöperation in his efforts to treat them medically.

The members of the Academy individually contributed through their stories to the gaiety of the occasion, and the dinner itself was followed by a most interesting presentation of an analysis of the distribution by age of infant mortality.

Under the very efficient leadership of Harold A. Murray, M.D., as Chairman, the Program Committee provided an interesting and satisfactory evening, which was enjoyed by the members. Thanks were extended to Dr. Murray's committee and to Dr. Fries for their contributions.

## CHILD HEALTH DAY PROCLAMATION

On February 16, President Roosevelt issued his annual Child Health Day Proclamation, designating the first of May as Child Health Day, and calling upon the people in each community to contribute to the conservation of child health. He especially urged that children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention.

Governor Edison has also issued a proclamation to the citizens of New Jersey to join in the efforts stressed by President Roosevelt in his annual Child Health Day Proclamation. State agencies of all kinds, interested in child

health, have been invited to aid in the development of a state-wide program of immunization planned and scheduled to achieve the purpose stated in these proclamations. Such agencies will include The Medical Society of New Jersey, the American Academy of Pediatrics (New Jersey members), State Department of Health, Health Officers' Association and other groups. Here is an opportunity for the physicians of New Jersey to set a definite period of time within which special inducements will be made to parents to have their children of all ages properly protected against these diseases as part of the protection of the civil population against the hazards faced at this time.

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## CONNECTICUT STATE MEDICAL SOCIETY SELECTS MEDICAL PERSONNEL

The Connecticut State Medical Society, at the request of the Personnel Department of the State of Connecticut, has accepted the responsibility of rating and classifying physician applicants for positions in the State service. Already an announcement under date of February 16 for open competitive examinations under the supervision of the Connecticut State Medical Society has been made for the following positions: Industrial hygiene physician, \$4500 per annum minimum, \$5280 maximum; crippled children physician, \$4500 per annum minimum, \$5280 maximum; child hygiene physician, \$4080 per annum minimum, \$4800 maximum; senior physician (psychiatric),

\$3240 per annum minimum (less maintenance), \$5160 maximum (less maintenance); assistant physician, \$2520 per annum minimum (less maintenance), \$3540 maximum (less maintenance).

Connecticut residence requirement is waived for these positions, but the candidates must be citizens of the United States.

Physicians in New Jersey interested in these positions may obtain more detailed information by writing to the Personnel Department of the State of Connecticut, State Capitol, Hartford, Conn. The last date for filing applications is March 16, 1942.

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## EMPLOYMENT OF GRADUATE NURSES IN APPROVED SCHOOLS OF NURSING

In the past the Board has expected every employed graduate nurse in an approved school of nursing to become registered in New Jersey. However, in the light of the present crisis and because of the shortage of nurses, the Board recommends consideration of the following adaptations for the *duration of the war only*:

1. That preference in employment be given to graduate nurses in the following order:

- a. Graduates of approved schools of nursing in the United States who are eligible for registration in New Jersey.
- b. Graduates of approved schools of nursing,

in the United States who are not eligible for registration in New Jersey.

2. That all those graduates who are eligible for registration be required to register.

3. That the status of all nurses be thoroughly investigated and determined in order to be certain that they are bona fide graduates of approved schools and not graduates of special hospital courses or other courses which do not prepare for the registered nurse examinations.

The records of all employed graduates should be filed, as usual, in the Board office and the legal status of each nurse determined. Full coöperation will be given by the Board and cases reopened for consideration upon request. When the nurse is notified of the Board's action regarding her creden-



tials, the school of nursing employing her will also be notified.

(Nurses in group 1b should not be given assignments involving teaching in relation to the education of student nurses.)

4. That the school of nursing act on these adaptations in the light of their own standards of nursing care for their patients and their school of nursing standards.

NOTE: The nursing practice act with regard

to the legal status of registration remains the same, namely that no person shall practice the profession of nursing and in conjunction therewith shall in any way represent that he or she is a registered nurse, or shall use after his or her name the abbreviation "R.N." unless he or she is registered in New Jersey.

#### NEW JERSEY STATE BOARD OF EXAMINERS OF NURSES.

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## UNITED STATES PHARMACOPOEIAL CONVENTION

A meeting of the United States Pharmacopoeial Convention is called to be held at Hotel Statler, Cleveland, Ohio, on April 7, 1942, to receive the report of the Committee on Constitution and By-Laws provided for by the resolution introduced by Dr. Morris Fishbein at the 1941 convention in Washington, D. C. The resolution referred to is as follows:

Resolved, That the President and the Board of Trustees be authorized to appoint a committee of nine, consisting of four physicians, four pharmacists, and one representative of a governmental agency, and including the President, the Secretary, and the Chairman of the Revision Committee ex-officio, to make a revision of the Constitution and By-Laws of the United States Pharmacopoeial Convention; and that this revision be submitted to the Convention at a special session to be called by the Board of Trustees not more than two years from the date of adjournment of the present session; and that the following principles be especially consid-

ered in the preparation of the proposed revision of the Constitution:

"1. The development of a representative body of a size capable of functioning efficiently.

"2. Suitable and proportional representation for medicine, pharmacy, governmental agencies, dentistry, veterinary medicine, and manufacturing pharmacy.

"3. Selection of well-qualified experts to undertake the necessary periodic revision of the Pharmacopoeia.

"4. Selection of a governing body or board of trustees with continuous overlapping terms of office to provide for continuity of policy and action.

"5. Revision and publication every five years with interim supplements.

"6. Establishment of fundamental criteria for admission of drugs and preparations to the Pharmacopoeia.

"7. Establishment of a full-time executive staff without personal affiliation with any private agency."

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## WHAT IS HAPPENING TO BOTANICAL DRUGS?

The following is an abstract of an article which appeared in *The Apothecary*, a Journal for the Progressive New England Druggist, in the September, 1941, issue. Physicians will learn from this abstract the reasons for the curtailment in the availability of certain drugs, the origin of which they may have forgotten.

Botanical drugs are still available at increased cost and in limited quantities from the following countries:

In Europe, Spain and Portugal still make available on a precarious scale such important drugs as Aconite, Ergot, Gentian and one or two of lesser importance.

From French African possessions it is still possible to obtain Coriander, Horehound, Red Squill, Sandarac and some Orris.

From Egypt, Acacia, Colocynth, Henna and Senna are available.

India, in spite of the bad shipping situation, furnishes occasional supplies of Senna.

The Japanese Agar Agar, Camphor and Menthol have been cut off and Chinese supplies come only occasionally.

Our Latin-American neighbors in South America are becoming increasingly important sources of supply, but too much reliance cannot be placed on these countries for immediate replacement of goods formerly produced elsewhere.

Labor shortage has materially affected many of the domestic botanicals with consequent advance in price.

The Persian supply is threatened with stoppage and certainly with interference and delay. There are some eight or ten raw products originating in Persia, the outstanding one being Gum Tragacanth.

Following is a partial list of botanicals in moderately good supply at this time: Aloes, Curacao, USP; Aloes, Cape; Angelica Root, Domestic; Anise Seed, Star and Green; Arabic Gum, Areca Nuts, Asafoetida Gum, Benzoin Gum, Berberis Root, Black Haw Bark, Blood Root, Boneset Herb and Leaves, Buchu Leaves, Cardamom Seed, Cascara Bark, Cassia Bark, Chamomile Flowers, Cinchona Bark, Cube

Root, Dandelion Root, Derris Root, Doggrass, Ephedra Herb, Ergot, Fennel Seed, Foenugreek Seed, Galangal Root, Ginger Root, Golden Seal Root, Grains of Paradise, Grindelia Herb.

Henna Leaves, Horehound Herb, Ipecac Root, Irish Moss, Jalap Root, Juniper Berries, Kamala, Karaya Gum, Kola Nuts, Lady Slipper Root, Laurel Leaves, Lavender Flowers, Lemon Peel, Licorice Root, Lobelia Herb, Mandrake Root, Myrrh Gum, Nutgalls, Aleppo and Chinese; Oak Moss, Olibanum Gum, Orange Peel, Sweet and Bitter; Pichi Tops, Pink Root, Poke Root and Poke Berries, Prickly

Ash Bark, Psyllium Seed, Pyrethrum Flowers, Quassia Chips, Quince Seed.

Rose Buds, Pale; Rosemary Leaves, Sabadilla Seed, Saffron, Spanish; Saint John's Bread, Sandalwood Chips, Sarsaparilla Root, all grades; Sassafras Bark, select; Senega Root, Senna Leaves T. V., Sloe Berries, Soap Bark, Squill, red; Squill, white; Tamarinds, Tonga, Tonka Beans, Tragacanth Gum, Uva Ursi Leaves, Valerian Root, Wahoo Bark, White Pine Bark, White Pine Compound, Wild Cherry Bark, Wormseed, American; Yerba Santa, Zedoary Root.

## OBITUARIES

### DR. BRYAN C. MAGENNIS

Dr. Bryan C. Magennis, 83, one of the most prominent surgeons and physicians of Paterson, died on February 17, following a short illness. Dr. Magennis was graduated from the New York College of Dental Surgery in 1880. After practicing dentistry for a year, he entered the medical school of the University of New York, from which he was graduated in 1883. Dr. Magennis then became house surgeon for the Paterson General Hospital. For a time he was an assistant to the staff, and in 1891 was elected a member of the staff and visiting surgeon.

He was also visiting surgeon of the Miriam Barnert Memorial Hospital. He served three terms as a member of the Board of Health and health officer of Paterson.

Dr. Magennis was a member and Past President of the Passaic County Medical Society, a Fellow of the American College of Surgeons, and was greatly interested in the Paterson Philharmonic Society.



### DR. ELLSWORTH E. CONOVER

Dr. Ellsworth E. Conover, 80, of Hasbrouck Heights, a practicing physician there since 1895, died on February 14 after an illness of two weeks.

Dr. Conover spent most of his life in Hasbrouck Heights. He was on the staff of Hackensack Hospital, a member of the Bergen County Medical Society and formerly was active in fraternal orders.

### DR. WILLIAM H. HICKS

Dr. William H. Hicks, Newark psychiatrist, died on February 13, 1942, after a lingering illness. Dr. Hicks, who was 79, was born in Tennessee. He was graduated from New York University in 1893. Dr. Hicks was first assistant physician of Essex County Hospital for the Insane when the institution was in Newark.

Dr. Hicks was an honorary life member of the Academy of Medicine of Northern New Jersey.

### DR. RICHARD J. BROWN

Dr. Richard J. Brown died suddenly of pneumonia on February 4, 1942, in the Presbyterian Hospital of Newark, where he was Chief of the Obstetrical Staff. He practiced obstetrics in Essex County for thirty years, having an office at his home in South Orange, and also one in Newark. Dr. Brown, who was 58, was a member of the South Orange Village Board of Trustees.

Dr. Brown received his medical degree from New York University Medical College in 1909 and served his internship at Newark City Hospital. He was a consultant on obstetrics for Essex County Isolation and East Orange General Hospitals. He was Secretary of the Medical Board of Presbyterian Hospital and a member of the staff of Newark City and Babies' Hospital.

Dr. Brown was a member of the Essex County Medical Society, The Medical Society of New Jersey, Academy of Medicine of Northern New Jersey, the Practitioners' Club, the Doctors' Club, the Osler Club, and the New Jersey Society of Surgeons.

### DR. FRANK D. SCUDDER

Dr. Frank D. Scudder, 54, of Montclair, died of a heart attack on February 7, following a bowling tournament. Dr. Scudder was born January 25, 1888, at San Antonio, Texas. He received his medical degree in 1914 from the College of Physicians and Surgeons of Columbia University and served his internship at St. Luke's and Sloans Maternity Hospitals, New York.

Since 1919 Dr. Scudder had practiced general surgery in Montclair, specializing in conditions requiring radium. He had been Attending Surgeon and Director of the Radium Department at Mountainside, Attending Surgeon at Essex County Isolation Hospital and Consulting Surgeon at Newton Memorial Hospital. Dr. Scudder was a Fellow of the American College of Surgeons, and a member of the American Board of Surgery, the Essex County Medical Society, the Society of Surgeons of New Jersey and the Associated Physicians of Montclair.

DR. EDGAR A. ILL

The death of Dr. Edgar A. Ill in Newark on February 1 brought to a close the career of one of Newark's leading physicians. Dr. Ill had been



President of the Staff of St. Barnabas Hospital, and was attending surgeon at St. Michael's Hospital in Newark, and he was also consultant to Muhlenberg Hospital in Plainfield, the Rahway General and Irvington General Hospitals.

Dr. Ill was born in Newark on July 30, 1882. His early education was obtained in the

public schools of Newark. He was graduated from Princeton University in 1906 and from the College of Physicians and Surgeons, Columbia University, New York, in 1910. He also studied at the University of Berlin and was a Past-President of the Essex County Medical Society and a member of the American College of Surgeons, American Urological Society, as well as The Medical Society of New Jersey.

He was a member of the Newark Board of Education for eight years and in 1937 ran on the reform ticket for the office of City Commissioner of Newark.

Dr. Ill had been ill for several months with a severe heart ailment. He was the son and grandson of notable Newark physicians, and his cousins are also members of the profession.

Dr. Ill enlisted as a first lieutenant in the Medical Corps of the Army in the first World War, and was stationed at Camp Greenleaf, Georgia. His hobbies were yachting and fishing.

He is survived by his wife; one son, Edward J.; two daughters, Mary Ann Ill and Mrs. Julia M. Case of Montclair; three sisters, Mrs. Florence Hensler, Summit; Mrs. Edna O'Malley, Long Island, and Mrs. Clothilda Scheller, Newark.

At the time of his death Dr. Ill was Chairman of the Advisory Committee on Cancer Control of The Medical Society of New Jersey.

DR. HARRY JARRETT

Dr. Harry Jarrett, one of the oldest practicing physicians in South Jersey, died at the age of 75 at his home in Moorestown on January 29, as a result of injuries suffered in an automobile accident.

Dr. Jarrett was very active in general practice until the time of his death. He had received a certificate of honor from the Camden County Medical Society for having completed 50 years of active practice in his profession.

Dr. Jarrett graduated from Jefferson Medical College in 1887 and in the same year he became first resident physician of Cooper Hospital.

Dr. Jarrett was a member of Camden City and County Medical Societies, The Medical Society of New Jersey and the Philadelphia Pathological Society.

DR. ALFRED J. DRURY

Dr. Alfred J. Drury of Roselle died on January 24 at his home following a heart attack. Dr. Drury, who was 45, was a member of the Union County Medical Society, The Medical Society of New Jersey, and a member of the staffs of the Elizabeth General Hospital, St. Elizabeth Hospital and Rahway Memorial Hospital.

Resolutions were passed by the Union County Medical Society proffering condolences to the bereaved family. Dr. Drury stood high in the professional and personal esteem of his colleagues. This was attested in the resolutions presented to his family.

The body was sent to Kingston, Ontario, Canada, for interment.

DR. W. KEMPTON BROWNING

Dr. W. Kempton Browning of Camden died on January 22 at Cooper Hospital of pneumonia, with cardiac complications. He was 67 years old and had practiced for 45 years in Camden and Merchantville. He was a graduate of Hahnemann College and was Vice President of the Pennsylvania Academy of Physical Medicine. Dr. Browning was a member of the Camden County Medical Society, The Medical Society of New Jersey, American Congress of Physical Therapy, and one of the founders of the Physicians Motor Club and its secretary-treasurer for 25 years.

DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
James P. Morrill	65	Dec. 14, 1941	Paterson	Paterson	Toxemia. Uremia.
Anthony Parisi	48	Dec. 18, 1941	Newark	Newark	Coronary occlusion.
Charles D. Ripley	77	Dec. 25, 1941	East Orange	Point Pleasant	Coronary thrombosis.



# Letters to the Journal

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Letters commenting on material in the *Journal*, as well as suggestions for the welfare of the Society, may be directed to "The Editor", Medical Society of New Jersey, 143 East State Street, Trenton. The Publication Committee reserves the right to edit, reject or abbreviate any letters submitted.

## NATIONAL PHYSICIANS' COMMITTEE

Dear Mr. Editor:

I have read with interest the article "New Jersey Physicians Committee Formed" in the January issue of the *Journal* of The Medical Society of New Jersey.

Nothing in the article has led me to change my opinion expressed in a letter I wrote to Dr. Hayden, Secretary of the National Physicians Committee, on December 15, 1939. I believe that now more than ever we need to use the full force of the A. M. A. and its component societies without any added "side shows" to detract from the "Big Tent".

We will always have two-fisted, convincing professional organizers with us. They use their right hand for their Dale Carnegie gestures and their left to show you where to sign on the dotted line. Let's direct our excess effort in getting all the eligible physicians of New Jersey within the ranks of organized medicine before we dilute our strength with "just one more organization".

This matter of the National Physicians Committee for the Extension of Medical Service was thoroughly discussed at the Welfare Committee meeting and by the New Jersey delegates to the A. M. A. Since personal opinions were on December 7th, according to your record, accepted on their face value, I should like to state as my opinion that it was misleading for Mr. Pratt to say that leaders of the A. M. A. have, in general, endorsed the program. There are many leaders of the A. M. A. who have expressed to me in person and by letter approval of the enclosed letter.

It is interesting to note that at the December 7th meeting of the subscribers to the National Physicians Committee only one side of the question was presented.

HILTON S. READ, M.D.

## IN REPLY

To the Editor:

Since the organization of the New Jersey Committee of the National Physicians' Committee on December 7, 1941, many letters of support and inquiry have come to us. We appreciate very much the fine report of the organization meeting which was made in the January issue of this *Journal*.

The National Physicians' Committee came into being at a time when rapidly changing conditions were creating new problems that demanded solution by the medical profession. For a number of reasons existing medical organizations were inadequate to this pressing need.

We have received quite a few letters asking why is there a need for a new organization and why cannot the American Medical Association do all of this work?

There are definite reasons:

1. By virtue of its charter provisions and its program of operation over a period of more than ninety years, the A. M. A. has been accorded the status of a non-profit, scientific, educational foundation. As such, it has been granted exemption from Income and Social Security taxation. A departure from established practice would, in all probability, entail the forfeiture of this status. This, in turn, would entail exorbitant taxation and lead to really serious complications.

2. There are many lay groups and individuals who are vitally affected by present medical trends and who are as much interested in the solution of the problems as are the physicians. The support of all interested should be enlisted. The A. M. A., as such, could not ask for nor accept financial support from many of these. As a case in point, the findings of the Council on Pharmacy could not be kept free from suspicion

if the A. M. A. were accepting substantial contributions from a drug manufacturer.

We are now at war. It is fully understood that our first task and our first obligations are to make the maximum contribution to the war effort. War-time changes are creating a new need and a greater field of usefulness for the National Physicians' Committee.

The National Physicians' Committee seeks the moral and financial coöperation of all physicians, lay individuals and lay groups who are interested in the new medical problems and their solutions.

(Signed) CHESTER I. ULMER,

Chairman New Jersey State Committee, National Physicians' Committee.

## ERYTHREMIA

Dear Editor:

In response to the Editor's note on page 20 of the January 1942 issue of this *Journal*, asking for any reports of cases of "Erythremic Response to Liver Therapy in Pernicious Anemia", as reported by Dr. Paul B. Ferrary, the writer calls attention to the following references in the foreign literature:

Emile-Weil et Boic. Le Sang (Paris) 6:685-690, 1932, and discussions.

F. Hogler (Vienna), Klinische Wochens. 9: No. 44, 2052-2058, Nov. 1, 1930 (see pages 2054-2056).

Jakob Pal (Vienna). Lancet (London) 2: No. 5442, page 1315, Dec. 17, 1927.

Julius Bauer. Wiener Klinische Wochenschrift 44: No. 20, page 656, May 15, 1931.

G. A. Birnie (Melbourne). Med. J. of Australia 23:11, page 498, October 10, 1936 (Sydney).

HYMAN I. GOLDSTEIN, M.D.,  
Camden.

## • THE BULLETIN BOARD •

A course in amputations will be given at the Rehabilitation Clinic in Newark every Saturday morning from *March 14* through *April 25*. Each session begins at 9:00 a. m. and lasts two hours. The regular tuition fee is \$25.00, but officers in the Medical Corps of the Army and Navy may take the course without fee. The instructor will be Lieutenant Commander Henry H. Kessler (U.S.N.R.). Only physicians who are on the surgical services of hospitals recognized by the American College of Surgeons, or who are Fellows of that College, or who are Diplomates of the American Board, are eligible.

The Gloucester County Medical Society will hold its March meeting at the Woodbury Country Club on Thursday, *March 19*, at 9:00 p. m. Dr. Leonard G. Rowntree of Philadelphia will speak on "Arthritis".

A short course in oral pathology is announced by Columbia University for five Wednesday evenings at 8:00 p. m., beginning on *April 1*. Total tuition fee is \$10.00, which should be sent to the Registrar, School of Oral Surgery, 630 West 168th Street, New York.

Dr. William D. Stroud, Professor of Cardiology, Jefferson Medical College, will speak to the Essex County Medical Society on Thursday evening, *April 9*, at the Academy of Medicine. Dr. Stroud's subject will be "Modern Therapeutics in Cardiology".

The preliminary program for the Second American Congress on Obstetrics and Gynecology is now available. The Congress will be held in the St. Louis Auditorium, St. Louis, Mo., *April 6 to 10, 1942*. A special feature of the Congress will be an "Obstetrics Information Please" hour on three days, at which time the attendants are asked to try and stump the experts. Clinical conferences, consultation service and clinical demonstrations will be held. Preliminary programs may be obtained from the office of The American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago, Ill. Fred L. Adair, M.D., is the General Chairman.

The American Association of Industrial Physicians and Surgeons, and the American Industrial Hygiene Association will hold their joint Annual Convention in Cincinnati from *April 13 to April 17, 1942*. Important medical and hygienic problems associated with the present huge task of American industry will be presented and discussed in clinics, lectures, symposia and scientific exhibits.

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons, announces an essay contest with a prize of \$150.00 for a manuscript of not more than 5,000 words on any obstetric or gynecologic subject or on any branch of abdominal surgery. Three copies of the manuscript must be in the hands of the Secretary by *June 1, 1942*. An application blank and further rules may be secured from Dr. James R. Bloss, 418 Eleventh Street, Huntington, W. Va.

The National Gastroenterological Association will hold its seventh annual convention in New York City on *June 3, 4 and 5*. The delegates from the New Jersey Gastroenterological Society are Drs. Sigurd W. Johnsen, Passaic; Manfred Kraemer, Newark, and Hyman I. Goldstein, Camden.

The Medical Society of New Jersey is well represented at the Stark General Hospital in Charleston, S. C., with three captains in the Medical Corps. Dr. John E. Davis and Dr. Elic A. Denbo of the Mercer and Camden County Societies, respectively, are attached to the Neuropsychiatric Section, and Dr. Walter H. Hagen of Essex County is attached to the Orthopedic Section.

Dr. Manfred L. Gorten of Newark, a member of the Essex County Medical Society, has become a Diplomat of the American Board of Psychiatry and Neurology.

Dr. Henry A. Davidson, Editor of this *Journal*, has been ordered by the War Department to active duty at the Army Medical Center in Washington.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

DR. JOSEPH T. BEARDWOOD, JR., Assistant Professor of Medicine, University of Pennsylvania Graduate School of Medicine, was the guest speaker at the February 13 meeting of the *Atlantic County Medical Society* at the Hotel Traymore in Atlantic City. His topic dealt with the newer concepts of diabetes mellitus. He emphasized the fact that diabetes is on the increase in the United States and that it is found in 2 per cent of the population. The greatest increase in incidence of diabetes has been in children (35,000 children in this country with diabetes below the age of 14) and women between the ages of 40 and 55 years. Diabetes is becoming a greater Public Health problem each year. The relation of diabetes to the glands of internal secretion was discussed. Dr. Beardwood considered the various types of insulin in the treatment of diabetes and stressed the value of using high carbohydrate diets, and particularly adequate diets in children so that there would be no stunting of growth. After a few general remarks about hereditary factors in diabetes and a warning against any of the fads used in treatment, there was a general discussion which was opened by DR. CLARENCE L. ANDREWS and DR. SAMUEL L. SALASIN.

DR. HARRY SUBIN, President of the Society, opened the business meeting. Aside from the usual communications and reports, there were several announcements of importance. DR. ROBERT DURHAM announced that instead of the usual post-graduate course this winter there would be a refresher course in war medicine, for six weeks starting February 25th. DR. I. RAVDIN will be the first speaker, giving his experiences at Pearl Harbor.

Everyone was urged to be present at the Fifth Councilor District meeting at the Northfield Country Club on March 13, 1942, at 6 o'clock. An announcement was made of the State Medical Meeting from April 21 to 23, and that the program would be mostly defense problems. DR. NORMAN SCOTT, Medical Director of the Medical Service Administration of New Jersey, said that the Medical Service Plan had been accepted but that there was a change in policy of Plan 2. It will operate jointly with the Hospital Service Plan of New Jersey and there will be a change in income levels. The meeting adjourned at midnight.

### BERGEN COUNTY

Rudolph C. Schretzmann, M.D., Acting Secretary

The regular meeting of *Bergen County Medical Society* was held at Englewood Hospital, Englewood, New Jersey, on February 10. Meeting was called to order by the President, DR. H. B. WILSON, at 9:15 p.m.

DR. ROBERT LEVY, Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University and Director of Cardiology Department, Presbyterian Hospital, spoke on "Left Chest Pains", pointing out that cardiac pain in the left chest is

caused chiefly by coronary insufficiency, aortic valvular disease, anemia, paroxysmal tachycardia, hyperthyroidism, and any of the above combined states. Seven conditions which simulate pain produced by cardiac conditions are: acute pericarditis, poisoning by coffee, tea or tobacco, thoracic aortic aneurysm, intercostal neuralgia or myalgia, duodenal ulcer, cholelithiasis, and psychoneurotic states. Diagnosis of coronary occlusion, according to the speaker, is best substantiated by fever, increased sedimentation rate, tachycardia, leukocytosis, electrocardiographic changes, elevated venous pressure and fall in systolic pressure. A test for coronary insufficiency was described in detail, consisted of breathing in a mixture of 10 per cent oxygen and 90 per cent nitrogen until left chest pain was experienced. It was pointed out that this is merely a test of functional capacity of the coronaries and not of their anatomic status. Statistics presented demonstrated that aminophyllin and nitroglycerin given intravenously relieved coronary pain the longest. Aminophyllin given by mouth was also effective. Surgical treatment of coronary pain was discussed and para vertebral alcohol block was described in detail. The latter treatment is rated the safest and more effective. An interesting and stimulating question period followed this excellent course.

The minutes of the last regular meeting and the last Executive Committee meeting were read and approved.

A letter from the Medical Society of Atlantic County presenting DR. HILTON S. READ's name as candidate for office of Second Vice-President of the State Society was read.

Communications from New Jersey Defense Council, Medical Service Administration of New Jersey, Board of Medical Examiners of the State of New Jersey and Medical Society of New Jersey were outlined.

The following were elected to membership:

To Junior Membership, DR. JOHN J. DALY, Teaneck; Regular Membership, DR. DOROTHEA D. VANN, Englewood; Regular Membership by transfer from New York County Medical Society: DR. JULIUS A. KLOSTERMAN, Hackensack.

DR. WILSON presented the report of a special committee which was appointed to solve the problem created by the illness of MR. WHITEHEAD, Executive Secretary. It was decided to grant him a leave of absence for six months.

DR. SPENCER T. SNEDECOR announced that the McClave bill, changing the status of attempted suicide from a criminal to medical case, is before our State legislative body. It was brought out that this bill is a culmination of many years of effort in this direction on the part of DR. F. S. HALLETT. DR. WILSON reviewed the interest and recommendations of our Executive Committee in connection with this problem in the past.

DR. VICTOR A. BLENKLE, Chairman of the Nominating Committee, submitted the following report: Delegates to the New Jersey State Medical So-



ciety, 1942-1944: Delegates, Joseph R. Morrow, Arcangelo Liva, William L. Vroom, George M. Knowles, G. Barton Barlow, Victor A. Blenkle; Alternates, Louis A. Hitzemann, Lyman Burnham, William C. Rucker, Norman Myers, Conde DeS. Pallen, Henry D'Agostin.

If another Delegate and Alternate are accredited to the Bergen County Medical Society: Delegate, George M. Levitas; Alternate, L. G. Nicol.

State Nominating Committee: Delegate, Harrison Betts Wilson; Alternate, George M. Knowles.

All candidates were duly elected.

### BURLINGTON COUNTY

J. Bruce Dickson, M.D., Reporter

The monthly meeting of the *Burlington County Medical Society* was held on January 12, 1942, in Moorestown, N. J.

The President, DR. DEAN H. LE FAVOR, welcomed DR. HARRY NELSON of Gloucester County and DR. ALAN SHAFFER of the Zurbrugg Memorial Hospital.

The guest speaker, DR. EDWARD A. SCHUMANN of Philadelphia, was introduced by DR. RICHARD ANDERSON. Dr. Schumann's topic was "Some Obstetrical Dilemmas". He discussed many problems which confront the obstetrician. He believed that the remedy for the toxemia of pregnancy would be found in the nutritional field, which is certainly a new angle for such an old problem.

The discussion which followed was opened by DR. JOSEPH KUDER and lasted almost as long as the original speech. However, it was equally as interesting and informative.

The Burlington County Medical Society went on record as being against any yearly registration fee for the physicians of New Jersey which several of the adjacent states have adopted.

### CAPE MAY COUNTY

Alexander C. Moon, M.D., Acting Reporter

A regular meeting of the *Cape May County Medical Society* was held on January 27, 1942, at the Douglass Hotel, in Wildwood. Members attending were Samuel Hughes, Mace, Hornstine, Cohen, Corson, Townsend, Crowe, Cryder, Brooks, Frank Hughes, Robbins, Moon, Friedland, Monosson.

After a general discussion it was decided that an acting secretary should be appointed to carry on the duties of Dr. Way during his absence. It was to be definitely understood that Dr. Way will remain the Secretary of the Society, with an acting secretary doing his work. DR. ALEXANDER MOON was chosen.

It was decided that DR. HUGHES should temporarily perform the duties of Dr. Way as Field Physician for The Medical Society of New Jersey.

DR. CORSON reported upon a meeting of the Legislative Committee held in Ocean City on January 21, 1942, which was attended by SENATOR SCOTT and ASSEMBLYMAN BOSWELL and DR. QUIGLEY from State Headquarters, at which a proposed chiropody bill was discussed, and ways and means were considered to combat passage of unfavorable legislation in the future from the standpoint of the good of the communities in the state.

DR. CORSON was appointed to function for Dr. Way as Chairman of the Post-Graduate Education Committee to attend to arrangements for the next course. DR. CRYDER and DR. CROWE were named to serve on this committee.

DR. BROOKS reported no progress by the Conference of Allied Medical Professions, in coöperation with pharmacists, dentists and nurses.

There was a general discussion concerning the attitude of the members of the Society in the matter of the possibility of having to function with osteopaths not licensed to practice medicine and surgery, chiropractors, etc., in line of duty in Civilian Defense activities. It was decided that there is no need for action by the Society at this time.

DR. TOWNSEND was appointed Local Chairman of a Committee in National Medical Defense, upon the request of Dr. Kilduffe for such an appointment.

DR. FRANK HUGHES reported upon a meeting attended in Atlantic City which was addressed by DR. FISHBEIN.

A letter was read from Mrs. Oswald R. Carlander, President of the Woman's Auxiliary to The Medical Society of New Jersey. She expressed regret of her organization in the matter of the disbandment of the Woman's Auxiliary to the Cape May County Medical Society.

It was moved by Dr. Cryder, seconded and passed, that the Secretary forward a letter to Mrs. Carlander stating that the Society has voted that the Auxiliary should be maintained if possible, and that reports upon the efforts to bring this about would be sent to her as soon as possible. It was also recommended that copies of the above letter should be sent to Mrs. Townsend and members of the Auxiliary.

DR. Samuel Hughes proposed that all members of the Society prevail upon their wives to become active members of the Auxiliary.

DR. FRANK HUGHES reported satisfactory progress upon the part of the Committee for Venereal Disease Control.

DR. NEWBURGH intimated that the State Department of Health is discouraged by the lack of activity in some clinics, and is anxious for the work to continue, as well as in other lines of public health work.

DR. FRIEDLAND spoke upon the laxity of law enforcement, compelling delinquent patients to continue treatment.

DR. F. HUGHES suggested that definite court action is available, and reported very good results from the use of such agencies.

A letter from COMMISSIONER ELLIS of the Department of Institutions and Agencies was read concerning the need for a licensed hospital at Whale Beach.

It was moved by Dr. Cryder, seconded and passed, that Mr. Ellis be informed that in the opinion of the Society, existing facilities in Sea Isle City and Ocean City are sufficient to care for the Whale Beach area.

DR. Robbins moved, and it was seconded and passed, that DR. MOON be appointed to act as alternate for Dr. Way, as Nominating Delegate to the State Society meeting in Atlantic City in April of

this year. This is to provide for the possibility that Dr. Way might not be able to attend this meeting.

Dr. Brooks moved, and it was seconded and passed, that Dr. MOON function as Acting Reporter for the Society during the absence of Dr. Way.

Dr. F. B. LANE HAINES of Ocean City and Dr. ALEXANDER A. S. STUART of Sea Isle City were unanimously elected to membership in the Cape May County Medical Society, with the reservation that the Secretary obtain from the applicants the proper applications made personally, and checks for the annual dues.

Dr. Robbins moved, and it was seconded and passed, that before the end of February, 1942, there should be an audit of the Treasurer's books for the preceding calendar year, a report to be filed at the next meeting. Dr. Brooks and Dr. Cryder were named as a committee to conduct.

The meeting adjourned to the dining room for sandwiches and coffee.

### CUMBERLAND COUNTY

Earl C. Lyon, M.D., Reporter

Numerous matters of business were taken up at the meeting of the *Cumberland County Medical Society* held on February 10 at the Cumberland Hotel, including the granting of a transfer of a member and the resignation of another. Dr. AUGUST JONAS, formerly of Bridgeton, requested a letter of transfer to the Salem County Medical Society and Dr. CLIFFORD BAKER of Vineland presented his resignation, which was accepted. Dr. Baker is in the U. S. Army and expects to specialize in x-ray work.

The Atlantic County Medical Society presented the name of Dr. HILTON S. READ as a candidate for the post of Second Vice-President of The Medical Society of New Jersey.

Dr. THOMAS K. LEWIS asked the Society for an expression of opinion on the subject of an annual state registration of physicians, the proceeds being designed to support the State Board of Medical Examiners, and the majority of the members in attendance voted against the registration project.

The Society also voted against the adoption of what is known as "hospital plan number two" as advocated by the New Jersey Medical Service Administration.

The scientific program was presented by Dr. FRANKLIN PAYNE, Professor of Gynecology at the University of Pennsylvania. It was announced that the meeting of the Fifth Councilor District will be held March 13 at 8 p.m. at the Northfield Country Club.

### ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine in Newark, January 8, 1942. Dr. FRANCIS C. WEBER, President, called the meeting to order at nine o'clock.

The speaker of the evening, Dr. W. WAYNE BABCOCK, Professor of Surgery, Temple University School of Medicine, Philadelphia, spoke on "The

Practitioner's Surgery". In his own inimitable way, he presented his listeners with a rare treat. He showed us the surgery that came up to us in our every-day life, with emphasis on the simpler things and how to treat them. He stressed the importance of rest to any member of the body if ill or operated upon. He showed that although medicine and surgery are progressive, we sometimes "about face" and make use of the good methods of earlier days. Lantern slides did much to make the talk more understandable. Illustrations were shown of many of the cases cited. The meeting was well attended.

Those of our members who have been following up the Newark Evening News and reading the Saturday night column of "Timely Medical Topics" can be proud of the work which is being done by the members writing this column. Such recent ones as "Burns" and "Civilian Medical Defense" are "tops". The Public Relations Committee is to be congratulated.

A very interesting and well-attended meeting of the Lung Committee of the County Society was held at the Presbyterian Hospital on January 6. Dr. I. P. BORSHER conducted the meeting and Dr. GRANT THORBURN, Attending Physician to the Pulmonary Disease Service of Lenox Hill Hospital, New York, was guest speaker. Interesting pulmonary cases from the hospital were presented by Dr. HENRY ORTON, Dr. R. N. DIEFFENBACH and Dr. I. P. BORSHER. The cases were then discussed by Dr. THORBURN. Dr. Thorburn had practiced in Newark prior to 1917. All of us who knew him then have a warm spot in our memories for him.

The Medical Preparedness Committee, working in conjunction with the Graduate Instruction Committee, should feel highly honored by the attendance at the lectures prepared by them. The speakers were excellent. They had their subjects under command. Those who were fortunate enough to be able to attend received all that they came for. Your reporter attended those given at the City Hospital and the reports of those attending at other points were similar. This series was one of the highlights of this administration.

The following candidates were all elected to membership in the Essex County Medical Society: Active—Dr. I. K. DARBY and Dr. E. ROSEN of Newark; Associate—Dr. M. R. BERLIN and Dr. E. F. DELIA of Newark, and Dr. K. K. JACKSON of East Orange.

### GLOUCESTER COUNTY

At the regular meeting of the *Gloucester County Medical Society* on February 19 Dr. WILLIAM W. PEDRICK, Chairman of the Medical Preparedness Committee, stated that several physicians were still needed for the various local Defense Councils. Dr. WENDELL J. BURKETT, Chairman of the Legislative Committee, announced that an annual registration of all physicians in the State of New Jersey had been recommended. Dr. RALPH K. HOLLINSHED

moved that the Gloucester County Medical Society approve of such a registration.

DR. JOSEPH C. YASKIN, Professor of Neurology, University of Pennsylvania Graduate School, talked on "The Neuroses from the Standpoint of the General Practitioner". He stated that the center factor of all psycho-neuroses is anxiety. In all cases there is some disturbance of the vaso motor system, acting secondarily on the various viscera. A satisfactory etiological diagnosis cannot always be made due to the neurotic make-up of the individual.

The treatment of neuroses is still very little understood. There is no standard method of treating such diseases at the present time. The treatment, however, consists of treating:

1. The underlying causes.
2. Present symptom.

The factors necessary in treatment:

1. Complete history.
2. Complete physical examination.
3. Necessary laboratory studies.
4. Aeration of the mental traits.

### HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on January 6 at the Masonic Club, Jersey City, N. J., with DR. A. J. CONTY presiding.

A special Bulletin to Officers of Component County Medical Societies was received from The Medical Society of New Jersey. This report was read in part and due to its length will be placed on file.

A communication was received from DR. CHARLES H. SCHLICHTER, Chief of the Emergency Medical Services of the New Jersey Defense Council, which gave a list of physicians who have been appointed Chairmen of Committees on Health and First Aid by the local defense councils. It was advised that the Chairman of the Committee on Health and First Aid be also appointed as Chief of Emergency Medical Services in the local Defense Area.

The men appointed for Hudson County are as follows:

Guttenberg: DR. GEORGE F. PILTZ

Jersey City: DR. GEORGE O'HANLON, DR. SAMUEL

A. COSGROVE, DR. CHARLES P. DEFUCCIO

Kearny: DR. G. H. VAN EMBRUGH, JR.

Secaucus: DR. ANTHONY T. STOKES

A communication was received from MR. DENNIS J. SULLIVAN, Chief Health Officer of the Jersey City Department of Health, asking the President to appoint a member of the Hudson County Medical Society to serve with the Committee on Health Education. This committee is part of the Civil Defense effort of the Jersey City Department of Health. DR. CONTY appointed DR. CLAUDIO E. MCNENNEY to serve on this Committee representing the Hudson County Medical Society.

A communication received from the Secretary of The Medical Society of New Jersey in connection with the proposed amendment to the Constitution was read. (See page 36, January *Journal*.)

A communication was received from Dr. William

J. Carrington stating that the Atlantic County Medical Society will present the name of Dr. Hilton S. Read for the office of Second Vice-President of The Medical Society of New Jersey at the next Annual Meeting.

The following communication was received from Dr. Norman M. Scott, Associate Chief of the Emergency Medical Services, New Jersey Defense Council:

"For purposes of Civilian Defense, New Jersey has been divided into five regions. An office of the New Jersey Defense Council has been established in each region. Attached to each office will be a Deputy Chief of E. M. S. This office requests that County Societies give full support to the activities of the Deputy of E. M. S."

(For a list of the Deputy Chiefs, see page 12, January *Journal*.)

The following applicants were elected to membership: DR. KATHARINE A. GURLEY and DR. ISRAEL N. SCHENKER of Jersey City. Transfer from New York County Medical Society: DR. HILDA C. FLIEGEL of Jersey City.

DR. HARRISON F. FLIPPEN, Associate in Medicine, University of Pennsylvania, spoke on "Cardinal Principles of Sulfonamide Therapy". The paper was discussed by several members and the discussion was terminated by Dr. Flippen.

There being no further business, the meeting adjourned at 11:15 p. m.

### HUNTERDON COUNTY

Jack E. Shangold, M.D., Reporter

The regular winter meeting of the *Hunterdon County Component Medical Society* was devoted to the subject of Civilian Defense. DR. NORMAN M. SCOTT of the State Emergency Medical Services office and DR. DAVID B. ACKLEY, Commander of the Trenton District, were the principal speakers. DR. A. DUNBAR HUTCHINSON of Trenton, the third guest of honor, took part in the discussion. Local First Aid Chairmen, members of the Society, outlined the local plans to be used in their respective communities.

The regular business meeting was preceded by a turkey dinner held at the Union Hotel, Flemington, on Tuesday evening, January 27, at 9 o'clock. There were nineteen members and the three guests present, with DR. RAYMOND J. GERMAIN, the President, presiding.

### MERCER COUNTY

A. D. Hutchinson, M.D., Reporter

The *Mercer County Component Medical Society* met in the Stacy-Trent Hotel, Trenton, on February 11, with the President, DR. HAROLD C. COX, presiding. Due to unavoidable circumstances the guest speaker was unable to be present, and the President opened the meeting for business discussion.

The Treasurer reported 100 per cent paid members, with one member dropped, and 22 now serving in the Armed Forces.

A communication from PRESIDENT LEWIS relative to Annual Registration was discussed. The Society went on record as favoring Annual Registration.



The Society moved to support HILTON S. READ for the office of Second Vice-President.

An invitation from the Union County Medical Society to hear PROFESSOR JAMES M. MACKINTOSH, Gas Prophylaxis Officer of Great Britain, speak on "Medical Aspects of Civilian Defense" was read and commented upon.

The following were elected to active membership: DRs. L. M. BERRY, R. C. MILLER, S. J. VENTO and G. A. WILDMANN. DR. M. P. CHARNOCK was elected to associate membership.

### MIDDLESEX COUNTY

Cyril I. Hutner, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on January 21, 1942, and was called to order by the President, DR. MATTHEW F. URBANSKI, at 9:00 p.m. The minutes of the previous meeting were read and approved.

DR. PHILIP MANGOGNA, formerly of Newark and now a resident of Perth Amboy, was accepted as an active member by transfer from the Essex County Medical Society.

DR. THEODORE BOYT of South River was accepted as an associate member.

A letter from MR. JOHN HOAGLAND, President of the Pharmaceutical Society, advising that the druggists would like to regulate prescription blanks by printing them through the Society, either with an insignia or with the list of approved druggists on the reverse side of the blanks, was read.

A motion was made to refer the matter to the Professional Relations Committee. The motion was passed.

A letter of resignation was received from DR. CHARLES H. CALVIN as Field Physician in Middlesex County. This resignation creates an opening for another field worker in this county and the matter was referred to the Maternal Welfare Committee.

A letter from Dr. Barkhorn advised that the Editor of *The Journal* is available for talks to the Society to review the materials of the Society for publication. This was referred to the Program Committee.

A motion was made by DR. A. URBANSKI that delinquent members be contacted to find out whether they would apply for honorary membership before any definite action is taken. The motion was passed.

Dr. Urbanski welcomed the members of the Dental Society, who had been invited to attend this meeting.

Sound motion pictures were shown through the courtesy of the New Jersey Defense Council. The first one depicted what is actually going on in London and how the people are trained to conduct themselves during air raids. The second one showed the method of dealing with incendiary bombs.

The program continued with a round table discussion on "Preparedness in Medical Defense" and the following speakers outlined their work in the setting up of medical defense measures: DR. R. L. McKiernan, Chief, Emergency Medical Service of the New Jersey Defense Council; DR. MARSHALL SMITH, Chairman, Subcommittee on Medical Aid

under Committee on Disaster, Preparedness and Relief; DR. JOSEPH M. GUTOWSKI, Chairman, Middlesex County Medical Society Committee on Medical Preparedness, and Medical Aid Local Defense; DR. NORMAN M. SCOTT, Secretary, The Medical Society of New Jersey Committee on Medical Preparedness; and Miss EMMA McCLoud, Director, New Brunswick Visiting Nurse Association.

A vote of thanks was given to the speakers and to MR. ANTHONY GUTOWSKI for presenting the moving pictures.

DR. WILLIAM C. WILENTZ informed the members that it is not necessary to send in any more of the printed questionnaires, as there was now in progress a new one which will take care of any further information the Assignment and Procurement Service might need.

"The Star-Spangled Banner" was then sung by the audience under the leadership of Dr. McKiernan, with Dr. M. F. Urbanski accompanying on the piano.

The meeting was adjourned and refreshments were served in the hospital cafeteria.

### MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular meeting of *Monmouth County Medical Society* was held on January 28, 1942, at the Monmouth Memorial Hospital. DR. B. W. MOFFAT called the meeting to order at 9:15 p.m. Thirty-five members were present.

Reading of the minutes of the previous meeting was omitted; they were printed in detail in the *Bulletin*.

A letter from Medical Service Administration of New Jersey relative to the operation of Plan 2 was approved and accepted on proper motion.

DR. J. A. FISHER gave a short talk on legislation now pending on medical problems.

DR. C. B. BLAISDELL gave a comprehensive report on the Welfare Committee meeting. He spoke regarding the doctors volunteering for service on the Induction Boards. No one volunteered.

DR. JOHN P. MOHAIR was elected to membership. Monmouth County Dental Society requested that they be allowed to work with Monmouth County Medical Society in furthering First Aid. The matter was referred to the Executive Committee for definite action.

Question was raised about payment of 1942 dues for members now in active service with the United States forces. We will remit the dues for all our members in active service.

The Treasurer made the suggestion that some of the savings account now in the Seacoast Trust Company be used to purchase bonds. We will invest \$1,500 in Defense Bonds.

DR. W. G. HERRMAN introduced the guest speaker, DR. BRADLEY L. COLEY of New York. Dr. Coley spoke on "Conservative Surgery in the Treatment of Bone Tumors". His paper and illustrations gave first-hand, instructive information of unusual interest. A question-and-answer period followed. Dr. Coley's presentation held the attention of all the members.

## MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

The regular February meeting was held at the N. J. State Hospital, Greystone Park, on February 19, President D. W. TELLER presiding.

It was announced that the next Maternal Welfare meeting would be held at All Souls Hospital, Morristown, the last Thursday in February, with DR. CARL ILL of Newark speaking on "New Classifications of Toxemias of Pregnancy".

The matter of the annual registration of physicians was discussed at length by DR. COSTELLO, and it was decided to consider this an open topic and not to instruct our delegates pro or con.

We were particularly fortunate to have DR. JOHN SCUDDER of the Presbyterian Medical Center in New York City for our fourth Post-Graduate lecture, who chose a timely topic, "The Modern Treatment of Shock". The group of nearly a hundred physicians was greatly impressed by the set-up and technique developed, and graphically illustrated by slides, movies and the actual apparatus. The speaker stressed the great significance of salt concentration in shock, and that in injuries with shock, hydration is necessary and not dehydration. He pointed out that in shock, the blood becomes heavier, and in wounds of all kinds there are associated changes in cells: (1) A decrease in potassium ion, (2) an increase in the sodium ion, (3) and an increase in the water of the cell. Cloudy swelling is nothing more than cells taking up water, therefore in dehydration you increase the water of the cells. He specifically referred to three tests used to determine water shifts: (1) Hematocrit, (2) the falling drop, and (3) the measurement of the plasma protein. It is thus possible to anticipate shock and institute appropriate treatment before the onset of an irreversible state of shock. The administration of normal saline and adrenal cortex was, of course, recommended, and blood transfusion as the first choice, and plasma as the second choice in restoring body fluids and protein, plasma having the definite property of restoring cardiac action and maintaining blood pressure. He indicated the importance of the establishment of blood banks in the various hospitals, and particularly to be careful of the technique used in obtaining blood, and in the processing of plasma, because of the dangers of contamination during the procedures necessary.

## OCEAN COUNTY

L. W. Falkinburg, M.D., Reporter

The monthly meeting of the *Ocean County Medical Society* was held on January 14, 1942, at the Forked River House in Forked River, N. J.

First speaker was DR. LEROY A. WILKES, who spoke on organized medicine. In his talk the history of organized medicine in New Jersey was briefly covered as well as some of the salient present-day problems of medical organization.

DR. ROBERT STURR, Associate in Roentgenology in the Jefferson Medical College of Philadelphia, presented a talk on the "Evaluation of X-Ray Therapy in Medical Practice".

The business meeting was given over to a consideration of medical problems of national defense.

## PASSAIC COUNTY

I. Okin, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held on February 12 at 9:00 p.m., at the Board of Health Building, Paterson. DR. SIGURD W. JOHNSEN, President, presided.

Resolution on the passing of DR. JAMES P. MORRILL was read as follows:

"DR. JAMES P. MORRILL passed from his earthly labors into the Life Eternal on December 14, 1941, after an illness of eight months. Born in Massachusetts of the oldest New England stock, he spent his entire professional life in Paterson. Graduating in medicine from Yale in 1901, he entered the Paterson General Hospital as an interne, and on completing his service there, opened his own office and began to practice. Bringing to his work a steadfast devotion to duty inherited from his Puritan forebears, a high moral integrity and a native interest in the scientific and technical problems of medicine, he grew steadily in the confidence and esteem of his professional colleagues and in the regard and affection of all his patients, in both his office and his clinic.

"Associated at first with the Paterson General and later, for many years, with St. Joseph's Hospital, Dr. Morrill attained wide recognition as an orthopedist and as chief of the fracture service. He became a member of this society in 1903; he was always more interested in its scientific than its organizational work, but served it as President in 1930.

"Wherefore, the Passaic County Medical Society resolves that, by the passing of Dr. Morrill, the medical profession has lost a friend and colleague whose scientific spirit, human sympathy, and high character will remain in our memory as an inspiration and example; and it directs that this minute be spread in full upon its records and a suitably prepared copy sent to Mrs. Morrill.

"(Signed) ELIAS J. MARSH, M.D.

JOSEPH V. BERGEN, M.D.

ORVILL R. HAGEN, M.D."

A communication from the Borough of North Haledon was read, asking doctors to please report infectious diseases.

The following were elected to active membership: DR. FLOYD FORTUIN and DR. ERICH WOLF, of Paterson; DR. GEORGE KRIEGER, DR. PETER ROSS and DR. MAX TEICHHOLZ, of Passaic.

The Society approved the annual registration of physicians plus the payment of the fee.

DR. JOHN E. LEACH introduced the speaker of the evening, DR. GORDON MCNEER, Assistant Surgeon, Memorial Hospital, New York City, who spoke on the topic "Gastrosocopy". Dr. McNeer showed many slides of photographs taken with a gastroscope and pointed out that lesions not shown by the x-ray were often found by this method. He stated that gastroscope and x-ray work together in the diagnosis of lesions of the stomach. This procedure is a routine one at the Memorial Hospital in New York in lesions of the esophagus or cardiac part of the stomach. He showed moving pictures of the technique of gastrosocopy.



## SOMERSET COUNTY

D. O. Hamblin, M.D., Secretary

A regular meeting of the *Somerset County Medical Society* was held at the Nurses' Home of Somerset Hospital on January 8, DR. LEWIS C. FRITTS presiding.

This being a program meeting, the minutes of the previous meeting were not read, and all but essential business matters were postponed until the next regular meeting.

The President read a letter addressed to him by the County Clerk, MR. WALTER CRATER, stating that he felt that there was no longer space in the County Court House for the Society records, which have been stored there for many years. DR. LANCELOT ELY, Custodian of the records, expressed the opinion that since these records occupied such a small amount of space, and since they were of great historical value to the community and were quite as important as the voluminous legal records which are kept there, every effort should be made to keep our records stored in the Court House. He then regularly moved that the Secretary be instructed to write a letter to the Board of Freeholders insisting that these records be filed there, since it is the only absolutely safe storage space which is available in the community. Seconded and passed.

A communication was read from MRS. PEABODY, representing the Curie Aid Groups, a lay organization interested in the care of indigent cancer cases, asking for the endorsement of the Society for the program and campaign in Somerset County of the Curie Aid. It was regularly moved, seconded and carried that this request be referred to the State Welfare Committee for their recommendation.

A letter was read with regard to the First-Aid Courses for physicians which are being urged upon the medical profession by the Committee on Medical Preparedness of the State Society, through its Chairman, DR. CHARLES H. SCHLICHTER. It was the feeling of the Society that as physicians, it would be a waste of time for them to take so-called "advanced" Red Cross courses. It was suggested, however, that the Secretary communicate with Dr. Schlichter and find out whether or not he was in a position to furnish instructions in the treatment of war wounds and concussion injuries used successfully in present warfare, since methods have changed appreciably in the past year or so.

The Secretary then stated that the Society records showed that DR. EVA SARGENT had been duly elected to membership in the Society on October 19, 1938, but had allowed her membership to lapse when she moved to Ohio. It was regularly moved, seconded and carried that Dr. Sargent be restored to active membership in the Society, since she is now residing in Somerville.

The President introduced the speaker of the evening, DR. ROBERT A. MATTHEWS, Assistant Professor of Psychiatry, Jefferson Medical College, who gave an interesting talk on the Recognition and Handling of Common Psychoneuroses, which was very well received by the members of the Society. At the conclusion of his talk, the pleasure and thanks of the Society were expressed.

## UNION COUNTY

Frederic W. Lathrop, M.D., Secretary

The regular meeting of the *Union County Medical Society* was held in St. Elizabeth's Hospital, Elizabeth, on November 12, 1941, with the President, DR. LORRIMER B. ARMSTRONG, presiding.

DR. NORMAN JOLLIFFE presented a detailed review of "Recent Clinical Applications of Vitamin Therapy", illustrated with excellent slides, and an active discussion followed. Dr. Armstrong thanked Dr. Joliffe for the practical applications he had indicated as a result of his wide experience.

The Chairman of the Old Business Committee, DR. JACOB REINER, read DR. NORMAN M. SCOTT's letter on Medical Service Administration Plan of New Jersey, in which the Board of Governors of the Medical Service Administration requests that the proposed changes in its contracts and administrative procedures be approved and accepted by Union County Medical Society. These proposed changes relate only to Plan No. 2, which provides payment for medical and surgical hospitalized patients. This plan provides for :

a. A joint administration with New Jersey Hospital Service Plan.

b. Approval of the inclusion of the spouse and minor children of the subscriber as beneficiary under Plan No. 2.

c. Elimination of the income level in Plan No. 2 and the substitution of a revised method of payment to participating physicians for medical care; namely that the payment for medical services be placed upon the basis of hospital accommodations selected by the patient.

d. Contract for single persons and for a family.

e. Approval of the following two resolutions:

I. Whereas, Medical Service Administration (a New Jersey non-profit corporation) is organized with the approval of The Medical Society of New Jersey for the purpose of issuing contracts providing payment for medical and surgical services, rendered under such contracts by fully licensed physicians and surgeons, with free choice of physician and patient relationship preserved: Now, therefore, be it resolved that The Medical Society of New Jersey and its component County Medical Societies hereinafter named, promise and agree that physicians and surgeons who are members of said respective Societies will be reasonably available to render the medical and surgical services in fulfillment of the provisions of such contracts now or hereafter issued by Medical Service Administration of New Jersey.

II. The Medical Society of New Jersey and its component County Medical Societies hereinafter named have promised and agreed that physicians and surgeons who are members of said respective societies will render the medical and surgical services in fulfillment of the provisions of such contracts now or hereafter issued by Medical Service Administration of New Jersey. In event a subscriber is unable to secure a physician or surgeon from the appended list, the Medical Director of Medical Service Administration of New Jersey will gladly cooperate in procuring an available physician or surgeon in New Jersey.



DRS. SCOTT and LANCE answered the various questions from the floor, and after an active discussion it was moved, seconded and carried that Union County accept Plan No. 2 as altered by the proposed changes and adopt the above resolutions.

DR. MAX ROSENBLATT, Elizabeth, was elected to membership.

As reported in the minutes of the Executive Committee meeting, DR. JOHN H. HAMLEY, Elizabeth, has been transferred to Essex County.

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### SUMMIT MEDICAL SOCIETY

Elwood H. Macpherson, M.D., Secretary

The January meeting of the *Summit Medical Society* was held in the Nurses' Home of Overlook Hospital on January 27.

DR. STEUART, the President, presided. There were 29 members and 5 guests present.

DR. BENSLEY announced that next week the American Red Cross was going to collect blood from donors and requested that Summit physicians volunteer to aid this group.

Speaker of the evening was DR. ROBERT R. WILLIAMS, Director of Bell Laboratories Research Division and synthesizer of Vitamin B<sub>1</sub>, whose subject was "The Discovery of Vitamins and Their Significance". This was illustrated with slides and elaborated upon by Dr. Williams' personal historic investigations. There was much discussion following the meeting.

A collation was later served to the members and guests present.

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### NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

C. C. Carpenter, M.D., Secretary

A discussion of atopic eczema was the principal theme for a meeting of the *Northern New Jersey Dermatological Society* on January 21, 1942, at the Academy of Medicine, with DR. S. OLEYNICK, President, leading the discussion. Two cases illustrating the difficulty in diagnosis and treatment were presented before the discussion.

The first case was presented by DR. IRVING LEHMAN of Newark. The patient was a white male, age 38. Onset of the disease had been in the summer of 1939, at which time it appeared over the sternum and the scrotum. It was intensely itchy and disappeared in the winter. A similar rash reappeared the following spring, extending over the entire body. It cleared up again when warm weather passed, but a recurrence was noted in May, 1941, clearing the following December. During the past month the patient has had gripe and the rash has reappeared. In form, it is a generalized follicular, erythematous eruption, involving the chest, abdomen, arms, legs,

neck, and scrotum. This man has also suffered from chronic nephritis for several years. However, a blood chemistry and blood count are normal, and a Wassermann negative. A biopsy reveals only the microscopic picture of a toxic dermatitis.

Most of the members were in accord with the diagnosis of toxic dermatitis, although they did not believe that this had anything to do with his chronic nephritis. Skin disturbances, as a rule, do not result from this cause, except where marked edema is present. Skin tests were not believed to be of much value in this type of condition, but the use of a passive transfer to a non-allergic member of his family might be of help. The possibility of a physical allergy to heat should be considered and it was suggested that steam baths might be tried, to see if they would aggravate the condition. In the treatment of this type of atopic eczema, auto-hemotherapeutic injections, a salt free diet, and soothing therapy, as well as the judicious use of x-ray, are very useful. Elimination diets have also shown their value, according to the members, in skin conditions of this type. No one reported any success with the use of histaminase by mouth, although desensitization with histamine acid phosphate might be worth considering.

DR. EVA BRODKIN of Newark presented a colored female, age 34, whose trouble began last spring with an eruption on the neck and chest, finally spreading to the arms. This shows a superficial, mottled type of pigmentation, which cultures for fungi prove negative. However, chromatopsychosis could not be definitely ruled out. The majority of the members believed this to be a contact dermatitis, possibly of the Berlocque type, which is caused by the Oil Bergamont, plus sun light. This woman had used toilet water, which frequently contains this essential oil. It was considered a good principle in this type of case to remove all cosmetics. Patch tests, as a rule, are inconstant, but where positive are usually of great significance.

DR. H. J. UDINSKY of Passaic reported the use of a new fungicide which is being used in Paterson and Passaic General Hospitals. It has been found to be 120 times more active than phenol. This substance is put in an ointment base and, as yet, has produced no primary irritations. The clinical results, although they have not been extensive, are very encouraging. Dr. Udinsky offered to send a supply of this ointment, of which the active ingredient is a 4 per cent dihydroxydichloraldiphenol-methane, to anyone interested.

DR. GEORGE K. TWEDDLE of Paterson invited the members to hold their March meeting at the Paterson General Hospital.

Due to unsettled conditions, it was decided not to make any move to organize a section of dermatology at the annual meeting of the New Jersey State Medical Society, to be held at Atlantic City this year.

# WOMAN'S AUXILIARY

## WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Chairman Press and Publicity

### COMING EVENTS

#### BURLINGTON COUNTY

April 6, 1942, 2:00 p.m.

Moorestown Community House, Moorestown  
Public Relations Meeting  
Tea

#### ESSEX COUNTY

March 24, 1942, 2:00 p.m.

Contemporary of Newark  
Speaker: Robert S. Goodhart, M.D.  
Subject: Nutrition in Defense  
Tea

#### HUDSON COUNTY

April 6, 1942, 2:00 p.m.

Y. W. C. A., 270 Fairmount Avenue, Jersey City  
Public Relations Meeting

Guests: Representatives of local women's organizations

#### GLOUCESTER COUNTY

March 19, 1942, 9:00 p.m.

Woodbury Country Club, Woodbury  
Business meeting

#### MIDDLESEX COUNTY

March 18, 1942, 8:30 p.m.

Residence: Mrs. Edward Klein, 136 Market Street, Perth Amboy  
Musical

#### PASSAIC COUNTY

March 16, 1942, 3:00 p.m.

Residence: Mrs. Peter DeBell, Summer Street, Passaic  
Business and social meeting

### WAR — MORALE — THUMBS UP

War has now come to our country.

Love of dear ones, country, friends, home, possessions, hopes, our way of life and traditions form the incentive to resist an aggressor. Pagan and brutal nations have threatened our way of life, with its freedom, liberty and right to worship God, but their acts have united our nation in a determination to resist, with all resources and an abiding faith in the justice of our cause and in Almighty God.

Let no one think that it will be easy to overcome these forces of evil. They have long prepared, while we must build up anew the war material and resistance of our allies and ourselves.

Constantly we will need to summon to our aid new and more powerful means for striking down the enemy and greater fortitude to endure trials. A common peril has united our nation as never before. A great building is but a collection of parts. Whatever each of us can do will become a part in the great edifice built by common service and welded together in the fires of sacrifice and devotion to our country. This nation will stand forth as an evidence of our fortitude, our morale and the kind of people we are. In our efforts to prepare for conflict and to resist destruction we must also continue to improve and preserve those customs and activities we have found to be good, for what is not carefully preserved tends to rust, decay and finally vanish.

One of the ways in which we may contribute to our defense efforts is in helping in the ef-

forts of our State Medical Society. The work of our committee in collecting data on the medical history of New Jersey aids the members to preserve the traditions of The Medical Society of New Jersey, many of which were born in the stress of war. A review of the State Society's long history is a definite contribution to morale. Our exhibition during the annual meeting will attract many members to this war meeting and will help to lighten the load of the men and women who are doing their utmost to be of service to our country, to its organizations and to each other.

May I expect that each of you will, because of the war, sustain your efforts to collect medical history data and send in art and hobby entries and that you will feel that such contribution on your part will be a definite aid to morale. Thumbs Up!

The annual meeting will be unusually early this year; letters soliciting entries have been sent to all county medical societies, auxiliaries, past and prospective exhibitors.

Mrs. Oswald R. Carlander, our President, has specifically requested presidents of County Auxiliaries to make every effort to have their Medical History Committees active in gathering data.

I hope you will cooperate to prove even under stress that we can do better than ever before.

MRS. ILY R. BEIR, Chairman,  
Art, Hobby and Medical History Committee.

## "H" Is for Hudson County

These articles, written by the Presidents of the County Auxiliaries, are published each month and describe the procedures, aims and pet projects of the County Auxiliaries.

As we think about our aims and accomplishments we are reminded of an old Indian prayer, used by the boys in summer camp at night around Council Ring: "O Thou Great Spirit, as we close our eyes in sleep this night, do You think that we have done enough today to earn the right to live—tomorrow?" We, the Hudson County Medical Auxiliary, hope we are earning that right.

Our aims are varied. We endeavor to make everyone in our midst, especially new members, feel at home.

Money is raised at one party a year for our Benevolent Fund. This fund is used to help doctors' families who are in distress. Two hundred twenty dollars was added to this fund through our January party.

Our members are active in lay organizations. Five-minute health talks are read before lay groups.

Our Public Open Health meeting is scheduled for April 6th.

The posters, "Doctors at Work", have been distributed, and questionnaires related to the National Emergency have been sent to our members.

As a manifestation of patriotism we bought a \$1000.00 Defense Bond, and our members are aiding in staffing booths in cooperation with the Defense Savings Committee.

We have had a speaker on "Nutrition", one on the "Housing Project", a Book Review, and a tour of the Tuberculosis Hospital.

Our March meeting is to include a tour of the Margaret Hague Maternity Hospital and a talk by our State President, Mrs. O. R. Carlander.

Our Auxiliary stands ever ready to cooperate with the State Auxiliary and the Hudson County Medical Society.

MRS. ANDREW C. RUOFF, President,  
Auxiliary to the Hudson County  
Medical Society.

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## CONVENTIONS GALORE

The Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey will be held April 21 to 23 inclusive, at Atlantic City. High spots on the program arranged by Mrs. David B. Allman are these: April 21, registration, Executive Board meeting and rolling chair ride for all members, gratis. April 22, business session, reading of reports, Auxiliary luncheon honoring Mrs. Oswald R. Carlander, Art and Hobby tea and the annual banquet of the Medical Society at which the Auxiliary members are hostesses. April 23, new Executive Board meeting, Mrs. J. Howard Hornberger presiding.

Haddon Hall will be the headquarters for

the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 8 to 12, inclusive. At this meeting the members of our own Auxiliary are going to be really busy, as we are to be hostesses to the National Auxiliary members. It is most important that Mrs. David B. Allman, Chairman of Arrangements, receive all possible cooperation. Let us assure her of a large turnout by spreading the word of the convention to our medical friends and their families. Tell them that reservations for this meeting should be sent immediately to Haddon Hall, Atlantic City.

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### Camden County

Mrs. E. Reed Hirst

The Executive Board of the *Woman's Auxiliary to the Camden County Medical Society* met on Tuesday, February 3, 1942, at the home of the President, Mrs. George B. German. There were 14 members present.

Reports from the Recording Secretary and Treasurer were accepted as read.

The next regular meeting will be held on March 3, 1942, at the home of Mrs. Joseph E. Roberts, Haddonfield, N. J. Mrs. Henry R. Tatem, in charge of the program for that day, announced the plans for a five-minute "Quiz", a five-minute paper on "Blood Transfusion Banks" and a half-hour play given by some of our own members.

Public Relations Chairman, Mrs. Oram R. Kline, announced that the Public Relations Meeting is



scheduled for March 17, 1942, at the Woman's Club, Camden, N. J. This will be an afternoon session, with two speakers, namely—Dr. Winifred C. Collis, London, England, from the British Library on Information of New York, who will talk on "London Hospitals in War Time". Dr. Herbert T. Kelley, Philadelphia, Pa., has chosen the topic "Vitamins".

Mrs. Robert S. Gamon, Hospitality Chairman, assisted by her committee, will serve tea during the social period following.

When the questionnaires on the survey of trained personnel available in Camden County are returned, the Chairman of Public Health will keep them on file. As members take courses their records will be recorded on the original questionnaire.

Due to illness, Mrs. Edward C. Pechin, Chairman of Sunshine Committee, resigned. Mrs. H. Wesley Jack was appointed to fill this unexpired term.

Mrs. German reported that the Friendship Dinner held January 19, 1942, was enjoyed and that representatives from six organizations of Camden County attended. This dinner will be held annually, and the members of the Council will consist of the President and three other members of each organization—Business and Professional Women, American Association of University Women, Women Realtors, Jewish Women, Soroptomist Club and Woman's Auxiliary to the Camden County Medical Society.

No regular meetings will be held and the organizations will take turns to act as hostess for the affair.

The annual Fashion Show and Card Party, for the benefit of the Camden County Tuberculosis Association and other charities, will be held on Monday, March 3, 1942, at 8 p.m., in the Hotel Walt Whitman Ball Room.

Mrs. William Braun, Chairman of Finance and General Chairman of the party, named the chairmen and committees and requested full coöperation of all the members.

Our hostess served a delightful tea following adjournment of the meeting.

### Essex County

Mrs. Frank S. Forte, Publicity Chairman

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, January 26, 2 p.m., at the Academy of Medicine, 91 Lincoln Park, Newark, N. J., preceded by an Executive Board meeting at 1 p.m. Mrs. Edward W. Sprague, President, presided and read a report from the State meeting.

Mrs. Frank Bien of Irvington, Program Chairman, introduced the guest speaker, Dr. F. Parker Willey of Newark, who gave a very interesting illustrated lecture on "The Mystery of Coronary Diseases".

At the meeting it was voted to give \$100 to the War Relief Fund of the Red Cross. Reports were received from the various chairmen.

Mrs. Clymont McArthur, Membership Chairman, proposed the following new members, who were duly accepted: Mrs. William Keim and Mrs. Louis Bender of Newark, Mrs. William H. Glass of South Orange and Mrs. N. M. Smith of Maplewood.

At the close of the meeting tea was served by Mrs. Sidney Keller and her committee.

### Hudson County

Mrs. James M. Murphy, Chairman Press and Publicity

A most interesting book review was the feature of the meeting of the *Woman's Auxiliary to the Hudson County Medical Society* held at 2 p.m. on February 2, 1942, at the Young Women's Christian Association, Jersey City. Mrs. Andrew Ruoff, the President, presided. Mrs. S. R. Arbeit of Jersey City was welcomed to the Society as a member.

Mrs. A. E. Jaffin, Chairman of the Entertainment Committee, reported that the proceeds of the Bridge Tea held January 24 in the Neptune Room of the Hotel Pierre in New York had increased our Benevolent Fund by more than \$200. The party was attended by about 200 members and their friends. Not only was the party a financial success but those attending will long remember a pleasant afternoon in attractive surroundings. Table prizes were unusual and 45 lovely door prizes were donated by members and friends.

Mrs. Perlberg, the Treasurer, reported that a \$1000 Defense Bond had been purchased and was in safe keeping. Mrs. A. L. Kruger, the Program Chairman, announced a tour of the Lafayette Housing Project in Jersey City, to be held on February 16 at the invitation of Mr. Thomas of the Housing Authority. Twenty members will avail themselves of this opportunity to become better acquainted with our city. The March meeting is to include a tour of the Margaret Hague Maternity Hospital unit of the Medical Center. Discussion of the Reciprocity Meeting to be held in April followed. We are desirous of obtaining an outstanding speaker at this, our yearly event, in the field of public relations.

After the business meeting Mr. David Armstrong, head of the English Department of the Emerson High School of Union City, reviewed A. J. Cronin's "Keys of the Kingdom". He described the book as "personality literature" and compared the hero, Francis Chisholm, to Thoreau and Socrates. The method of reviewing whetted one's curiosity to read the book. He gave an outline of the story and read well chosen passages to exemplify the style of the author and the philosophy of the hero.

### Union County

Mrs. Rowland P. Blythe, Reporter

With the President, Mrs. George Knauer of Elizabeth, presiding, the regular meeting of the *Woman's Auxiliary to the Union County Medical Society* was held at the Elizabeth General Hospital on January 14, 1942.

Mrs. Margaret Mearns, acting Home Demonstration Agent of Union County, gave an interesting talk on "Nutrition", emphasizing the importance of vitamins in the daily diet.

It was announced that the annual convention of the *Woman's Auxiliary to the New Jersey Medical Society* would be held on April 21, 22 and 23 at Atlantic City.

Following the meeting a social hour was enjoyed and refreshments were served.

## BOOKS RECEIVED FOR REVIEW

**PSYCHIATRIC SOCIAL WORK.** By Lois Meredith French. Pp. 334. N. Y., Commonwealth Fund. 1940. \$2.25.

**1941 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY.** Ed. by Joseph B. DeLee, A.M., M.D., and J. P. Greenhill, B.S., M.D., F.A.C.S. Pp. 704. Chicago, Year Book Publishers, Inc. 1942. \$3.00.

**DISEASES OF METABOLISM; Detailed Methods of Diagnosis and Treatment. A Text for the Practitioner.** Ed. by Garfield G. Duncan, M.D. Pp. 985. Philadelphia, W. B. Saunders Company. 1942. \$12.00.

**PRIMER ON THE PREVENTION OF DEFORMITY IN CHILDHOOD.** By Richard Beverly Raney, B.A., M.D., and Alfred Rives Shands, Jr., B.A., M.D. Pp. 188. Elyria, Ohio, National Society for Crippled Children, Inc. 1941. \$1.00.

**NASAL SINUSES; an Anatomic and Clinical Consideration.** By O. E. VanAlyea, M.D. Pp. 262. Baltimore, Williams & Wilkins Company. 1942. \$6.50.

**DIET IN SINUS INFECTIONS AND COLDS.** By Egon V. Ullmann, M.D. 2d ed. Pp. 185. New York, The Macmillan Company. 1941. \$2.00.

## BOOK REVIEWS

**Manual of the Diseases of the Eye for Students and General Practitioners.** By Charles H. May, M.D. 17th edition revised with the assistance of Charles A. Perera, M.D. Pp. 519. Baltimore, William Wood & Company. 1941. \$4.00.

The seventeenth edition of the "Manual of the Diseases of the Eye", published in June, 1941, needs no introduction to the medical profession. The first edition of this valuable book found its way into the hands of the general practitioner as well as the eye physician in 1900.

This edition, being the fifth revision in the past eleven years, bespeaks the desire of the author to keep the general practitioner as well as medical students up to date in medical and surgical ophthalmology.

There have been a few changes with new color plates added showing the Koch-Weeks and the Morax-Axenfeld Bacillus; the colored drawings of the latter as well as a number of photographs of other phases of ophthalmology. Some new illustrations have been added and others deleted.

LEE W. HUGHES.

**The Autonomic Nervous System; Anatomy, Physiology, and Surgical Application.** By James C. White, M.D., and Reginald H. Smithwick, M.D. Pp. 469. 2d ed. New York, The Macmillan Company. 1941. \$6.75.

The second edition of this outstanding monograph is welcome at this time, particularly because so much has been added to the field since the first edition.

The chapters on the anatomy and general physiology of the autonomic nervous system make this book unusually valuable. Critical evaluation of various surgical procedures directed toward excision and interruption of the sympathetic nervous system are to be found in several chapters pertaining not only to the highly controversial subject of hypertension, but also to angina pectoris, peripheral vascular disease, and the relief of various types of intractable pain.

Medical students, neurologists, neuro-surgeons, internists and general surgeons should all consider this a required monograph for their libraries.

C. ABBOTT BELING.

**Immunology.** By Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P. 2d ed. Pp. 639. St. Louis, C. V. Mosby Company. 1941. \$6.50.

"Immunology" is not merely a guide-book "for medical students and for others—who are interested in the underlying principles involved in infection, resistance, and diagnostic laboratory tests". It is a comprehensive survey of the more important achievements of man in a comparatively new branch of experimental biology. It does not confine itself to a discussion of immunity from the standpoint of the host-parasite relationship, but presents the problem in all its present-day ramifications. Included also are numerous laboratory procedures which should prove of value to the student and the technician. Much of the material has been drawn from original publications which are cited rather copiously at the end of each chapter.

The science of immunology, as it is understood today, was not always so broad in its scope. It found its origin in the early observation of man that certain diseases could only plague him once during his life-time. After infection and complete recovery, he could not reacquire these infections, i.e., he had become immune. With his insatiable curiosity and thirst for knowledge, man investigated this phenomenon and soon discovered possible explanations for this immunity. When, upon further investigation, he was able to duplicate the immune processes in the laboratory—the science of immunology was born. It subsequently grew wider and wider in scope as man learned that he could apply his newly discovered principles of immunity to biological phenomena generally considered as outside the realm of infection and resistance; for example, the discovery that the normal blood serum of one individual could agglutinate the normal blood cells of another, and the subsequent classification of blood into four groups.

However, even though man has made a great deal of progress since the days of Jenner, Pasteur, Koch, Metchnikoff, Ehrlich, et al., there is still very little known as to the true nature of the immune reaction. For the most part he is still working in the dark and with unknown substances. True, he has attempted to name and define the latter in biological terms, but until that day when the immunolo-

gist will be able to satisfactorily identify these substances—they will have to remain mere names, arbitrary names given to them because of the way they act. Therefore, it is very likely that our present conception of the immune process may change from time to time. Realizing this possibility, Dr. Sherwood advises the student as to the controversial nature of some of the proposed theories and cautions against the indiscriminate acceptance of them as true tenets of immunity.

MEYER A. LEVY, B.Sc.

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**Macleod's Physiology in Modern Medicine.** Edited by Philip Bard. 9th ed. Pp. 1256. St. Louis, C. V. Mosby Co. 1941. \$10.00.

The ninth edition of this famous work lives up to its predecessors. The original author, J. J. R. Macleod, a Canadian physiologist, had an able collaborator in Philip Bard, Professor of Physiology at Johns Hopkins University, who, in turn, has chosen nine well-known specialists to help make this book a real contribution to any practitioner desiring a sound physiological background.

It has an exhaustive bibliography of over 2,000 references divided by subjects, which is a worthwhile accomplishment in itself. Students and practitioners alike will find this a valuable basic addition to their libraries.

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**Neuro-anatomy.** By Fred A. Mettler, M.D., Professor of Anatomy, University of Georgia. Pp. 475, 337 illustrations (30 in color). St. Louis, C. V. Mosby Company. 1942. \$7.50.

That neuro-anatomy is one of the most involved and least comprehensible subjects in the curriculum will be conceded by most medical educators. Nor will medical students or practitioners disagree. For decades now, neuro-anatomists have been seeking a magic formula to simplify our grasp of the enormous and overlapping complexities within the master-organ of mankind, the human brain.

Dr. Mettler has made a distinct contribution to this effort. His book includes a generous review of the histology as well as of the gross anatomy of the nervous system. He has given more space to the autonomic system than most anatomists have allotted in their text-books. The illustrations are clean, helpful, and fresh. The 30 colored pictures make the structures leap vividly into the comprehension of any but the dumbest of readers.

If any fault may be found with this excellent hand-book, it is perhaps with the kangaroo-like arrangement of topics, which requires the reader to jump from a chapter on external anatomy, to one—pages later—on internal structures—and then, half-a-book further on, to the chapter on histology, in order to secure a complete view of a single

brain area. And some neurologists may feel that the author has been a bit skimpy in his treatment of the cerebellum.

These trivial faults, however, are counterweighed by Dr. Mettler's emphasis on the clinical aspects of anatomy. This is reflected by his stress on the functions and interrelations of the organs of the nervous system, and by the frequency with which structures are oriented *in situ*. For instance, a number of original photographs and sketches show the relation of parts of the brain to the corresponding parts of the living head.

Dr. Mettler properly underlines the importance of association pathways, and illustrates these channels by several highly original photographs and drawings. He views all structures in transverse and longitudinal planes, grossly and microscopically, so that if one does not mind constant index-thumb-ing, an exceptionally well-rounded picture of each cerebral area is secured. In his treatment of the basal ganglia and cortex he presents modern concepts of localization and function which stamp this as a definitely "1942" volume.

HENRY A. DAVIDSON, M.D.

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**Hippocratic Medicine; Its Spirit and Method.** By William Arthur Heidel. Pp. 149. New York, Columbia University Press. 1941. \$2.00.

In the short number of 149 pages, Professor Heidel has not only unfolded Greek medicine to us, but also has given us the benefit, in compact form, of his most scholarly and extensive investigations in this field. The critical evaluation of Hippocratic literature could only be presented in such manner by one who has lived with the ancient Greeks as well as with us. To do justice to this fine work, one should read it from cover to cover.

As Heidel points out, it makes little difference whether Hippocrates, his pupils, or his contemporaries wrote what are now often considered "The Works of Hippocrates". It is important, however, that we know what Hippocratic medicine stood for. The physician in those days was also a philosopher. He had an inquiring mind, seeking a distinction between cause and effect, health and disease, and the application of universal laws to human physiology. He knew the art of medicine, and although there have been many scientific advances since that time, the physician himself has changed little. As the Hippocratics said: "There are three factors concerned in every case: the disease, the patient and the doctor." Furthermore, "The physician is the servant of his art; the patient must fight the disease with the help of the doctor. Always, but especially in desperate cases, the help the doctor renders is largely spiritual; only a true man can give it."

C. ABBOTT BELING.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

March, 1942

No. 3

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“WE are all in it,” said the President the day after bombs dropped on Pearl Harbor. “Every single man, woman and child is a partner in the most tremendous undertaking of our American history.” The excerpts below, derived from three papers presented at the 37th annual meeting of the National Tuberculosis Association, indicate the important role played by the medical profession in the victory effort.

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### CIVILIAN HEALTH IN NATIONAL DEFENSE

The stem from which all manpower springs is the civilian population. The strength of the branch can be no greater than that of the stem. How strong is the stem? The findings of the National Health Survey made in 1935-36 give us some measure.

It may be estimated that 70 million sick persons each year lose over one billion days from work or customary activities and that the cost of illness and premature death in this country amounts annually to about ten billion dollars. The decline in the total death rate has been accomplished largely by live-saving in infancy and childhood, thus allowing larger numbers to reach the age of maturity. Consequently, there is an upward trend in diseases of middle and old age, such as heart disease, nephritis, cancer and diabetes.

More than half of all tuberculosis deaths occur in the age group 15 to 45. This heavy loss comes approximately within the age limits for military service. And for every death there are approximately 10 clinical cases of illness from tuberculosis.

Disabling conditions among children, dental defects, venereal diseases, pneumonia, malaria and accidents are other leading causes of death and disability. The mental hospitals contain about half a million inmates with 50,000 on parole and about 75,000 patients are in institutions for the feeble-minded and epileptic.

Studies of the economic status of families shows a direct correlation of sickness with low income. Disability due to illness was nearly two and one-half times as great among persons in the income group under \$1,200 (annually) as in the group above \$3,000. When it is recalled that the low income groups constitute a large proportion of those who are employed in industries more or less directly connected with national defense, the losses sustained as a result of unnecessary illness may be regarded in the light of domestic sabotage.

*Civilian Health as a Factor in National Defense,*  
K. E. Miller, M.D., *Amer. Rev. of Tuber.*, Dec., 1941.

### EXCLUDING TUBERCULOSIS FROM THE NAVY

Compactness of living spaces aboard a naval vessel is a necessity. Advances in ship construction from the standpoint of ventilation and sanitation in general have been made, but men living aboard are still somewhat crowded. Under such conditions an open case of tuberculosis is a real menace. Medical officers are on the alert, but the average sailor likes to think of himself as a rugged, hardy individual and will not, as a rule, report to the sick bay unless he really feels sick.

No applicant showing any degree of adult type tuberculosis is acceptable. Men in the service who

develop tuberculosis are retired and are not subject to recall to active duty, even with long standing arrest and minimal lesions.

The medical department of the Navy has recognized that at least 30% to 40% of minimal cases will be missed by well-trained phthisiologists depending upon the conventional methods of physical examination alone. The criterion to be used in weeding out tuberculosis must be radiography. What form of radiography might be most practical for the Navy has been studied for some years. After carefully weighing the advantages and dis-

advantages of the several methods now available, fluorography with the 35-mm. film was found to be the best solution to the problem.

Speed is an important factor during a period of mobilization. A smooth working team can easily turn out from 100 to 150 films per hour. At present, examinations are not exceeding the rate of 80 per hour in the interest of careful posturing and some regard for the life of the X-ray tube.

However, these miniature films are not used for fine diagnostic work, but serve merely as a sieve to screen out the abnormal from the normal chest. In any case showing a lesion or even a questionable area, a standard 14 x 17 inch celluloid film is made for confirmation and accurate diagnosis. The method has definitely passed the experi-

mental stage and it is ideal for mass thoracic survey work. At one training station photofluoroscopic examinations of 5,171 recruits were made. These men had already passed two stringent physical examinations. Yet, of these recruits, 15 men showing soft infiltration in the lungs and 3 with multiple calcification and fibrosis of a disqualifying extent were transferred to the hospital for further study and disposition.

The incidence of tuberculosis in the Navy during normal times is not high and has been steadily declining.

*Pulmonary Tuberculosis, Its Exclusion from the Navy, Robert E. Duncan, M.D., Amer. Rev. of Tuberc., Dec., 1941.*

## TUBERCULOSIS IN THE ARMY

The author's paper, presented May 8, 1941, was largely a criticism of certain faults in the program for detecting tuberculosis among inductees. By December, 1941, however, he was able to add to the summary the following:

"Since presenting this paper the Army Tuberculosis Survey has been improved. Practically all inductees are now being X-rayed prior to induction into the Army. Tuberculous inductees are not enrolled. It is considered that the Army now has an excellent program of tuberculosis survey."

The mobilization survey of 1941-45 will be the greatest case-finding effort ever carried out in this country. Its purpose will be to: (1) Detect chest diseases which would render the individual incapacitated for active military service; (2) detect diseases which may be so aggravated by military service that the individual becomes incapacitated for military service; (3) detect, especially, pulmonary tuberculosis with subsequent isolation from contact with young non-infected individuals; (4) report all tuberculous individuals to proper state health authorities.

The demobilization survey will consist of the routine general physical examination followed by an X-ray examination of the chest. Thus far, the X-ray examination has been made shortly after induction, and for this purpose the 14 x 17 inch film has been mostly used. At present and in the future the X-ray survey will be made chiefly by use of fluorograms, using the 4 x 5 inch films. Two films are made, one of which is sent to the War Department for permanent record. Upon demobilization, two additional fluorographic films will be made with like disposition of films.

The chief fault of this plan, namely, that the X-ray film of the chest is usually not made until after induction, has been corrected.

Another fault is that inductees may be discharged to their own care unless in need of hospitalization. Most medical officers will tend to err on the side of safety and many tuberculous inductees will be sent to Army hospitals who should have been discharged to their homes. When viewed from the standpoint of epidemiology, however, this may have the advantage of bringing a large number of cases under control and thus decreasing tuberculosis in the community.

Mobilization regulations allow the induction of an individual with reinfection tuberculosis when the process is minimal as to extent and arrested. This can be done when; in the opinion of the examiner, the lesion is not likely to become reactivated under the conditions of military service. This is a dangerous exception for many experts are able neither to estimate properly the true potentialities of a fibrous, tuberculous process nor the "conditions of military service."

Through this contemplated survey, thousands of new cases will be detected. It is important to plan for their care. No official estimate as to the number that will be discovered has yet been made but the author hazards the guess that between 1941 and 1945, a grand total of 88,000 cases will be detected.

*Tuberculosis in the Army, William C. Pollock, M.D., Amer. Review of Tuberc., Dec., 1941.*

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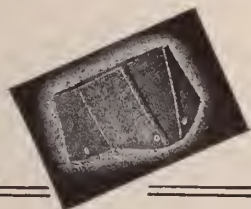
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### CONTENTS—Pages 183-248

	Page
ANNUAL REPORTS . . . . .	183
Index to Annual Reports . . . . .	184
Annual Reports of Officers and Committees . . . . .	185
AN ECHO FROM THE 1924 ANNUAL MEETING . . . . .	236
REFERENCE COMMITTEES . . . . .	237
PROGRAM OF THE ANNUAL MEETING—	
Woman's Auxiliary Program . . . . .	237
Schedule of Events . . . . .	238
Scientific Programs . . . . .	239-241
Scientific Motion Picture Theatre . . . . .	242
Scientific Exhibits . . . . .	243
Technical Exhibits . . . . .	244
TUBERCULOSIS ABSTRACTS . . . . .	248

Roster of Officers and Committees, Advertising Pages III-VIII

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WILLIAM K. CAMPBELL (1942) .....Long Branch  
HAROLD A. MURRAY (1944) .....Newark  
HAMMELL P. SHIPPS (1942) .....Delanco  
ILY R. BEIR (1943) .....Atlantic City

**Post-Graduate Education**

STUART Z. HAWKES, *Chairman* (1943) .....Newark  
DAVID F. BENTLEY, JR., *Vice-Chairman* (1943) .....Camden  
CLARENCE W. WAY (1944) .....Fort Dix  
ERNEST F. PURCELL (1944) .....Trenton  
ALBERT W. PIGGOTT (1942) .....Skillman

**Annual Meeting**

J. CARLISLE BROWN, *Chairman* (1943) .....Atlantic City  
WILLIAM J. CARRINGTON (1942) .....Atlantic City  
CLARENCE L. ANDREWS (1944) .....Atlantic City  
WILLIAM W. HERSOHN (1943) .....Atlantic City  
THOMAS MCG. BRENNOCK (1944) .....Jersey City

**Scientific Exhibits**

WILLIAM W. HERSOHN, *Chairman* (1942) .....Atlantic City  
SLOAN STEWART (1942) .....Atlantic City  
ROBERT B. DURHAM (1942) .....Atlantic City

**Scientific Program**

CLARENCE L. ANDREWS, *Chairman* (1942) .....Atlantic City  
STUART Z. HAWKES (1942) .....Newark  
JOHN W. GRAY (1942) .....Newark

**WELFARE COMMITTEE**

HILTON S. READ, *Chairman* (Atlantic County) .....Ventnor  
DAVID B. ALLMAN .....Atlantic City  
G. BARTON BARLOW (Bergen County) .....Englewood  
SPENCER T. SNEDECOR .....Hackensack  
JOSEPH M. KUDER (Burlington County) .....Mount Holly  
S. EMLEN STOKES .....Moorestown  
HENRY B. DECKER (Camden County) .....Camden  
GEORGE B. GERMAN .....Camden  
REUBEN L. SHARP .....Camden  
CLARENCE W. WAY (Cape May County) .....Fort Dix  
MILLARD F. SEWALL (Cumberland County) .....Bridgeton  
H. BURTON WALKER .....Vineland  
HARRY N. COMANDO (Essex County) .....Newark  
CHARLES M. ROBBINS .....Newark  
H. ROY VAN NESS .....Newark  
ROYAL A. SCHAAF .....Newark  
WENDELL J. BURKETT (Gloucester County) .....Pitman  
CHESTER I. ULMER .....Gibbstown  
REEVE L. BALLINGER (Hudson County) .....Arlington  
J. LAWRENCE EVANS .....Woodcliff  
BERTHOLD S. POLLAK .....Jersey City  
SAMUEL B. ENGLISH (Hunterdon County) .....Glen Gardner  
D. LEO HAGGERTY (Mercer County) .....Trenton  
WILBUR WATTS .....Trenton

JACOB J. MANN (Middlesex County) .....Perth Amboy  
RALPH J. FAULKINGHAM .....New Brunswick  
C. BYRON BLAISDELL (Monmouth County) .....Long Branch  
STANLEY H. NICHOLS .....Long Branch  
F. CLAUDE BOWERS (Morris County) .....Mendham  
BYRON G. SHERMAN .....Morristown  
J. EDWIN OBERT (Ocean County) .....New Egypt  
SIGURD W. JOHNSON (Passaic County) .....Passaic  
J. ALLEN YAGER .....Paterson  
C. SPENCER DAVISON (Salem County) .....Salem  
FRANK L. FIELD (Somerset County) .....Far Hills  
JAMES H. SPENCER, JR. (Sussex County) .....Franklin  
NORMAN W. BURRITT (Union County) .....Summit  
FREDERIC W. LATHROP .....Plainfield  
HERSCHEL S. MURPHY .....Roselle  
WILLIAM H. VARNEY (Warren County) .....Washington  
FREDERIC J. QUIGLEY, *Technical Adviser* .....Union City  
EARL F. S. HALLINGER, *Technical Adviser* .....Trenton  
SAMUEL BARBASH, *Technical Adviser* .....Atlantic City  
ROBERT P. FISCHER, Ph.D., *Technical Adviser* .....Trenton  
WILLIAM H. MACDONALD (Mr.), *Technical Adviser* .....Trenton  
WILSON G. GUTHRIE, *Technical Adviser* .....Trenton



## SUB-COMMITTEES TO THE WELFARE COMMITTEE

### Legislation

BERTHOLD S. POLLAK, <i>Chairman</i> .....	Jersey City
WENDELL J. BURKETT, <i>Vice-Chairman</i> .....	Pitman
WILLIAM C. WILENTZ .....	Perth Amboy
ROBERT E. WATKINS .....	Belmar
H. ROY VAN NESS .....	Newark
THOMAS E. MANLY .....	Paterson
JOSEPH M. KUDER .....	Mount Holly
THOMAS A. CLAY .....	Paterson
CHARLES MITCHELL .....	Trenton
FREDERIC J. QUIGLEY, <i>Executive Secretary</i> .....	Union City
SAMUEL ALEXANDER, <i>Consultant</i> .....	Park Ridge

### Medical Practice

REUBEN L. SHARP, <i>Chairman</i> .....	Camden
HENRY B. DECKER, <i>Vice-Chairman</i> .....	Camden
SIGURD W. JOHNSEN .....	Passaic
CHESTER I. ULMER .....	Gibbstown
SAMUEL BARBASH .....	Atlantic City
CEDRIC C. CARPENTER .....	Summit
WILLIAM K. HARRYMAN .....	Hackensack
A. CHARLES ZEHNDRER .....	Newark
ANDREW C. RUOFF .....	Union City
HERSCHEL S. MURPHY .....	Roselle
J. MALLORY CARLISLE .....	Westfield

### Public Health

STANLEY NICHOLS, <i>Chairman</i> .....	Long Branch
FREDERIC W. LATHROP, <i>Vice-Chairman</i> .....	Plainfield
ABRAHAM E. JAFFIN .....	Jersey City

### Public Health—Continued

ARTHUR W. BINGHAM .....	East Orange
JULIUS LEVY .....	Newark
ELBERT S. SHERMAN .....	Newark
C. BYRON BLAISDELL .....	Long Branch
ELMER P. WEIGEL .....	Plainfield
HENRY H. KESSLER .....	Newark
JOSEPH E. RAYCROFT .....	Princeton
THOMAS M. KAIN .....	Camden
MILLARD F. SEVALL .....	Bridgeton
CHESTER R. BROWN .....	Arlington
WILLIAM H. VARNEY .....	Washington
WILSON G. GUTHRIE .....	Trenton
HARVEY M. EWING .....	Montclair
HOWARD D. WHITE, <i>Technical Adviser</i> .....	Trenton
WILLIAM MACDONALD, <i>Technical Adviser</i> .....	Trenton
EMIL FRANKEL, Ph.D., <i>Technical Adviser</i> .....	Trenton
ELLEN C. POTTER, M.D., <i>Technical Adviser</i> .....	Trenton
ROBERT P. FISCHLIS, Ph.D., <i>Technical Adviser</i> .....	Trenton
WALTER G. ALEXANDER, M.D., <i>Technical Adviser</i> .....	Orange
J. M. WISAN, D.D.S., <i>Technical Adviser</i> .....	Elizabeth
MARGARET ASHMUN, R.N., <i>Technical Adviser</i> .....	Orange

### Public Relations

CHARLES M. ROBBINS, <i>Chairman</i> .....	Newark
G. BARTON BARLOW, <i>Vice-Chairman</i> .....	Englewood
LOUIS K. COLLINS .....	Glassboro
AUGUST H. GROESCHEL .....	Sussex
ROYAL A. SCHAAF .....	Newark
J. EDWIN OBERT .....	New Egypt
RALPH M. BUCHANAN .....	Phillipsburg
HENRY A. DAVIDSON, <i>Secretary</i> .....	Newark

## ADVISORY COMMITTEES TO THE SUB-COMMITTEE ON PUBLIC HEALTH

### Meetings at the call of the Chairmen

#### Adult Health Supervision

WILLIAM H. VARNEY, <i>Chairman</i> .....	Washington
HENRY H. KESSLER, <i>Vice-Chairman</i> .....	Newark
EDWARD C. KLEIN, JR. ....	Newark
LEE C. HUMMELL .....	Salem
IVAN V. SMITH .....	Pittstown
HAROLD A. KAZMANN .....	Long Branch
GEORGE J. McDONNELL .....	Freehold

#### Cancer Control

OTTO R. HOLTERS, <i>Vice-Chairman</i> .....	Asbury Park
WILLIAM A. ANTROPOL .....	Newark
WILLIAM G. HERRMAN .....	Asbury Park
PHILIP AVERY .....	Bound Brook
NICHOLAS M. ALTER .....	Jersey City
WILLIAM SPICKERS .....	Paterson
LEONARD S. SNEGIREFF .....	Trenton
CHARLES B. WOODMAN .....	Morristown
WILLIAM O. WUESTER .....	Hillside
THOMAS J. SUMMEY .....	Moorestown
FLOYD E. KEIR .....	Englewood
ALEXANDER M. CHRISTENSEN .....	Lebanon

#### Child Health

CHESTER R. BROWN, <i>Chairman</i> .....	Arlington
STANLEY NICHOLS, <i>Vice-Chairman</i> .....	Long Branch
WALTER B. STEWART .....	Atlantic City
ARTHUR F. ACKERMAN .....	Summit
ERNEST G. HUMMEL .....	Camden
CHARLES L. ROSENBERG .....	Newark
FREDERIC W. LATHROP .....	Plainfield
ARTHUR HEYMAN .....	Newark
J. PHILLIP STOUT .....	Jersey City
ROBERT E. WRIGHT .....	East Orange
JULIUS LEVY .....	Newark
IRVING OKIN .....	Passaic

#### Conservation of Vision

ELBERT S. SHERMAN, <i>Chairman</i> .....	Newark
GEORGE J. HOLMES, <i>Vice-Chairman</i> .....	Newark
HALVOR L. HALVEY .....	Atlantic City
WALLACE PYLE .....	Jersey City
ENOCH BLACKWELL .....	Trenton
CHARLES H. SCHLICHTER .....	Elizabeth
JAMES S. SHIPMAN .....	Camden
JOSEPH H. KLER .....	New Brunswick
WILLIAM E. BOOZAN .....	Elizabeth
DAVID C. BRAUN .....	Newton
JAMES A. FISHER .....	Asbury Park

#### Crippled Children

ELMER P. WEIGEL, <i>Chairman</i> .....	Plainfield
TOUFFIC NICOLA, <i>Vice-Chairman</i> .....	Montclair
FREDERICK G. DILGER .....	Hackensack
SETH B. SPRAGUE .....	Jersey City
OSWALD R. CARLANDER .....	Mercantville
JAMES P. PREGNALL .....	Asbury Park
JOHN E. TOYE .....	Arlington

#### Maternal Welfare

ARTHUR W. BINGHAM, <i>Chairman</i> .....	East Orange
J. CARLISLE BROWN, <i>Vice-Chairman</i> .....	Atlantic City
SAMUEL A. COSGROVE .....	Jersey City
WALTER B. MOUNT .....	Montclair
ROBERT A. MACKENZIE .....	Asbury Park
J. HARRIS UNDERWOOD .....	Woodbury
HARRISON B. WILSON .....	Hackensack
MAYNARD G. BENSLEY .....	Summit
CARL H. ILL .....	Newark
JULIUS LEVY .....	Newark
HANMELL P. SHIPPS .....	Delanco
WILLIAM M. SULLIVAN, JR. ....	Passaic
WILLIAM HEATLEY .....	Red Bank
GEORGE B. GERMAN .....	Camden
WILLIAM K. PUDNEY .....	Montclair

#### Mental Hygiene

JOSEPH E. RAYCROFT, <i>Chairman</i> .....	Princeton
JOHANNES F. PESSER, <i>Vice-Chairman</i> .....	Trenton
CLARENCE M. TRIPE .....	Asbury Park
WILLIAM M. DOODY .....	Jersey City
ARTHUR C. ZUCK .....	Washington
J. BERKELEY GORDON .....	Marlboro
CARL H. ILL .....	Newark
S. EMLEN STOKES .....	Moorestown
JEEMS B. SPRADLEY .....	Trenton
WALTER A. CRIST .....	West Collingswood
GEORGE STEVENSON .....	Red Bank
AMBROSE DOWD, <i>Technical Adviser</i> .....	Newark

#### Pneumonia Control

THOMAS M. KAIN, <i>Chairman</i> .....	Camden
FRED VOSBURGH, <i>Vice-Chairman</i> .....	Passaic
CHARLES F. RATHGEER .....	East Orange
CLAUDIO E. MCNENNEY .....	Jersey City
LEONARD M. BERMAN .....	Summit
FRANK J. ALTSCHUL .....	Long Branch

**Prevention and Control of Heart Disease**

HARVEY M. EWING, <i>Chairman</i> .....	Montclair
STANLEY NICHOLS .....	Long Branch
JEKOME G. KAUFMAN .....	Newark
LEROY W. BLACK .....	Rutherford
THOMAS J. WHITE .....	Jersey City
ALLEN RIECK .....	Pleasantville
EDWIN N. MURRAY .....	Camden

**Tuberculosis**

ABRAHAM E. JAFFIN, <i>Chairman</i> .....	Jersey City
JOSEPH R. MORROW, <i>Vice-Chairman</i> .....	Ridgewood
JOHN E. RUNNELLS .....	Scotch Plains
HAROLD S. HATCH .....	Morristown
SAMUEL B. ENGLISH .....	Glen Gardner
CLYDE M. FISH .....	Pleasantville
LEO B. DRAKE .....	Franklin
J. EARLE STUART .....	Plainfield
MARTIN H. COLLIER .....	Grenloch

STEPHEN A. DOUGLASS .....	Paterson
M. JAMES FINE .....	Newark
HENRY H. KESSLER, M.D., <i>Technical Adviser</i> .....	Newark

**Traffic Accidents**

MILLARD F. SEWALL, <i>Chairman</i> .....	Bridgeton
CHRISTIAN P. SEGARD, <i>Vice-Chairman</i> .....	Leonia
THOMAS S. P. FITCH .....	Plainfield
GARNETT SUMMERILL .....	Camden
ARNOLD VEY, <i>Technical Adviser</i> .....	Trenton

**Venereal Disease**

C. BYRON BLAISDELL, <i>Chairman</i> .....	Long Branch
JOSEPH E. HIGI, <i>Vice-Chairman</i> .....	Orange
JOHN S. KESSELL .....	East Orange
BAXTER A. LIVENGOD .....	Woodbury
IRVING LERMAN .....	Elizabeth
ARTHUR J. CASSELMAN .....	Trenton
DANIEL BERGSMAN, <i>Technical Adviser</i> .....	Trenton

## ADVISORY COMMITTEES TO THE SUB-COMMITTEE ON MEDICAL PRACTICE

**Meetings at the call of the Chairmen****Auxiliary Medical Services**

SIGURD W. JOHNSON, <i>Chairman</i> .....	Passaic
ARTURO R. CASILLI, <i>Vice-Chairman</i> .....	Elizabeth
EUGENE G. HERBENER .....	Lakewood
ROBERT W. DOW .....	Paterson
W. JAMES MARQUIS .....	Newark
ASHER YAGUDA .....	Newark
WILLIAM T. READ, JR. ....	Camden

**Contract Practice**

ANDREW C. RUOFF, <i>Chairman</i> .....	Union City
HARVEY T. HEROLD, <i>Vice-Chairman</i> .....	Newark
HENRY HAYWOOD .....	New Brunswick
EDWARD F. KLEIN .....	Perth Amboy

**Hospital Relationships**

HENRY B. DECKER, <i>Chairman</i> .....	Camden
SPENCER T. SNEDECOR, <i>Vice-Chairman</i> .....	Hackensack
GEORGE O'HANLON .....	Jersey City
CHARLES HYMAN .....	Atlantic City
EARL H. SNAVELV .....	Newark
JAMES H. SPENCER, JR. ....	Franklin
EDWARD A. Y. SCHELLENGER .....	Camden
REEVE L. BALLINGER .....	Arlington
EMIL FRANKEL, <i>Technical Adviser</i> .....	Trenton

**Industrial Health and Hygiene**

J. MALLORY CARLISLE, <i>Chairman</i> .....	Westfield
DONALD O. HAMBLIN, <i>Vice-Chairman</i> .....	Bound Brook
EDGAR E. EVANS .....	Pennsgrove
CEDRIC C. CARPENTER .....	Summit
H. IRVING DUNN .....	Elizabeth

**Medical Care of the Indigent and Low-Wage Groups**

HERSCHEL S. MURPHY, <i>Chairman</i> .....	Roselle
MERTON L. GRISWOLD, <i>Vice-Chairman</i> .....	Plainfield
ROBERT M. GRIER .....	Pleasantville
RAYMOND TAYLOR .....	Lakewood
FRANCIS C. WEBER .....	Newark
CHARLES E. SHARP .....	Port Norris

**Nursing and Nursing Education**

A. CHARLES ZEHNDER, <i>Chairman</i> .....	Newark
GEORGE M. KNOWLES, <i>Vice-Chairman</i> .....	Hackensack
HARRY SUBIN .....	Atlantic City
VICTOR KNAPP .....	Asbury Park
H. WESLEY JACK .....	Camden

**Pharmaceutical Problems**

CHESTER I. ULMER, <i>Chairman</i> .....	Gibbstown
REEVE L. BALLINGER, <i>Vice-Chairman</i> .....	Arlington
IRVING OKIN .....	Passaic
JACOB J. MANN .....	Perth Amboy
DANIEL W. TELLER .....	Morristown
THOMAS M. PASCALL .....	Newark

**Workmen's Compensation**

WILLIAM K. HARRYMAN, <i>Chairman</i> .....	Hackensack
JOSEPH F. LONDRIGAN, <i>Vice-Chairman</i> .....	Hoboken
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## SPECIAL COMMITTEE

**Medical Preparedness**

CHARLES H. SCHLICHTER, <i>Chairman</i> .....	Elizabeth
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DAVID A. KRAKER .....	Newark
HENRY B. DECKER .....	Camden
DAVID B. ALLMAN .....	Atlantic City
HAROLD D. CORBUSIER .....	Plainfield
ANDREW F. MCBRIDE .....	Paterson
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WILLIAM H. VARNKY .....	Washington

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MCIVER WOODY .....	Elizabeth
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ROBERT L. MCKIERNAN .....	New Brunswick
J. EDWIN OBERT .....	New Egypt
J. LAWRENCE EVANS .....	Woodcliff
D. LEO HAGGERTY .....	Trenton
EDGAR E. EVANS .....	Pennsgrove
E. LEROY WOOD .....	Newark
NORMAN M. SCOTT, <i>Secretary</i> .....	Trenton

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*President-Elect, Mrs. J. HOWARD HORNBERGER.....Roebling*  
*First Vice-President, Mrs. ALVAH W. BICKNER.....Rutherford*  
*Second Vice-President, Mrs. WM. D. MININGHAM.....Newark*

*Corresponding Sec'y, Mrs. LAWRENCE L. GLOVER..Haddonfield*  
*Recording Secretary, Mrs. BANKS S. BAKER.....Camden*  
*Treasurer, Mrs. THOMAS F. McCONAGHY.....Camden*

## PRESIDENTS, SECRETARIES AND REPORTERS OF COMPONENT COUNTY MEDICAL SOCIETIES

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BERGEN .....	Harrison B. Wilson, Hackensack..	G. Barton Barlow, Englewood ... Tel. 3-7121	Samuel C. Bump, Ridgewood
BURLINGTON..	Dean H. LeFavor, Palmyra .....	E. Warren Rodman, Beverly .....	T. Bruce Dickson, Riverton
CAMDEN .....	Arthur L. Stone, Camden .....	George B. German, Camden .....	Harold D. Barnshaw, Camden
CAPE MAY ....	Samuel B. Hughes, Cape May ...	Clarence W. Way, Fort Dix .....	Clarence W. Way, Fort Dix
CUMBERLAND.	W. Sherman Garrison, Cedarville.	F. Muriel Ramsey, Millville .....	Earl C. Lyon, Bridgeton
ESSEX .....	Francis C. Weber, Newark .....	Marcus H. Greifinger, Newark.... Tel. Waverly 3-2167	Paul H. Hosp, Newark
GLOUCESTER..	Frederick G. Wandall, Clayton ...	Chester I. Ulmer, Gibbstown .....	Clarence A. Bowersox, Woodbury
HUDSON .....	Anthony J. Conty, Union City ...	Thomas McG. Brennock, Jer. City. Tel. Journal Square 2-0787	John N. Connell, Jersey City
HUNTERDON ..	Raymond J. Germain, High Bridge	E. W. Lane, Bloomsbury .....	J. E. Shangold, Sergeantsville
MERCER .....	Harold C. Cox, Hightstown .....	A. Dunbar Hutchinson, Trenton... Tel. 3-5542	A. Dunbar Hutchinson, Trenton
MIDDLESEX ...	M. F. Urbanski, Perth Amboy....	C. Howard Rothfuss, Woodbridge. Tel. 8-0001	Cyril I. Hutner, Woodbridge
MONMOUTH ..	Barclay W. Moffat, Red Bank ...	William F. Jamison, Asbury Park. Tel. 5031	Murray Woronoff, Keyport
MORRIS .....	D. Woolsey Teller, Morristown....	George J. Young, Morristown .... Tel. 4-0662	Wilbur M. Judd, Greystone Park
OCEAN .....	Harry S. Ivory, Point Pleasant...	Louis R. Carmona, Tuckerton .... Tel. 133	L. W. Falkinburg, Forked River
PASSAIC .....	Sigurd W. Johnsen, Passaic .....	J. Allen Yager, Paterson .....	Irving Okin, Passaic
SALEM .....	Edgar E. Evans, Penns Grove....	Tel. Armory 4-2222 John S. Dunn, Salem .....	Lee C. Hummel, Salem
SOMERSET ....	Lewis C. Fritts, Somerville .....	Tel. 201 D. O. Hamblin, Bound Brook ...	S. S. Edelberg, Bound Brook
SUSSEX .....	Herbert M. Aitken, Ogdensburg..	Tel. 500 John E. Longnecker, Jr., Sparta..	Clifford M. Schmidt, Newton
UNION .....	Lorrimer B. Armstrong, Westfield.	Tel. Lake Mohawk 2061 Frederic W. Lathrop, Plainfield ..	Edward G. Bourns, Westfield
WARREN .....	Ralph M. L. Buchanan, Phillipsb'g	Tel. 6-0940 Neumann C. Marlett, Belvidere Tel. 99	Philip B. Kassow, Alpha

## FIELD PHYSICIANS OF THE COUNTIES

County	Name	Address	Telephone
ATLANTIC .....	J. Carlisle Brown .....	101 S. Indiana Ave., Atlantic City .....	5-4979
BERGEN .....	Lyman Burnham .....	229 Engle St., Englewood .....	3-1810
BURLINGTON .....	F. D. Fahrenbruch .....	101 Garden St., Mt. Holly .....	237
CAMDEN .....	Edmund Hessert .....	417 Cooper St., Camden .....	3382
CAPE MAY .....	Jules Cooper .....	Washington Ave., Woodbine .....	Bell 8-R-12
CUMBERLAND .....	J. S. Knowles .....	318 N. Second St., Millville .....	52
ESSEX .....	Alfred Muerlin .....	158 S. Harrison St., East Orange .....	Orange 5-9026
GLOUCESTER .....	Chester I. Ulmer .....	Gibbstown .....	Paulsboro 18
HUDSON .....	John J. McCarthy .....	616 35th St., North Bergen .....	Palisades 6-2385
HUNTERDON .....	P. W. Baker .....	High Bridge .....	170-R-2
MERCER .....	James R. Harman .....	824 W. State St., Trenton .....	3-0436
MIDDLESEX .....	Charles H. Calvin .....	80 Commerce St., Perth Amboy .....	4-0941
MONMOUTH .....	William Heatley .....	23 Monmouth St., Red Bank .....	80
MORRIS .....	George L. Nicoll .....	48 W. Blackwell St., Dover .....	180
OCEAN .....	George W. Gaumer .....	422 First St., Lakewood .....	81
PASSAIC .....	Theodore K. Graham .....	279 Park Ave., Paterson .....	Sherwood 2-9422 and 1607
SALEM .....	William T. Hilliard .....	105 Market St., Salem .....	332
SOMERSET .....	Samuel H. Pogoloff .....	Manville .....	Somerville 1228
SUSSEX .....	H. M. Aitken .....	Ogdensburg .....	Franklin 2002
UNION .....	Arthur E. Tator .....	57 DeForest Ave., Summit .....	6-0313
WARREN .....	Clyde Smith .....	167 W. Washington Ave., Washington ....	650





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In some patients with hyperacidity distinct benefit and relief of symptoms are obtained from the use of Geyser—the alkaline-saline water of the trio bottled for physicians' use.

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(MINERAL PARTS PER MILLION)

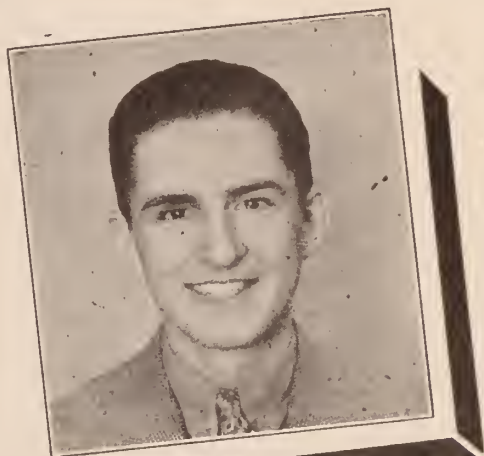
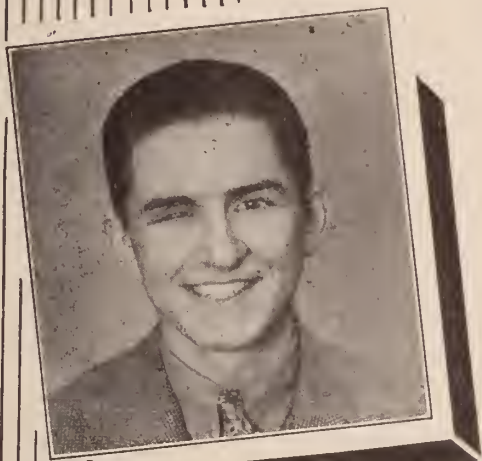
Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



## THE WATERS OF SARATOGA SPA

## *Full-Motioned, Lifelike* **ARTIFICIAL HUMAN EYES**



We have the Enviably Reputation of "Really Knowing How" to produce that "Pleasing Cosmetic Effect" so desired by one wearing an Artificial Eye.

### **REFERRED CASES CAREFULLY ATTENDED**

IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock

---

SELECTIONS SENT ON MEMORANDUM UPON REQUEST.

## **FRIED AND KOHLER, INC.**

*"Specialists in Artificial Human Eyes Exclusively"*

665 FIFTH AVENUE

near 53rd St.

NEW YORK, N. Y.

Tel. Eldorado 5-1970

*"Pleasing Particular People for Over Forty Years!"*

## Pollen parachute troopers are coming . . .

# HAY FEVER

**N**OW IS THE TIME to defend your patients against hay fever sensitivity. The preseasonal use of Lederle's modern methods of diagnosis, classification and treatment will often make innocuous the guilty air-borne invaders.

The strategy should include the following tactics:

- 1 - determine degree of sensitivity through the single scratch test with the proper Pollen Diagnostics;
- 2 - calculate suitable dosage indicated by the quantitative results of the tests;
- 3 - simplify the testing and treatment by using representative Pollen Diagnostics and Antigens;
- 4 - test for House Dust as a preliminary measure and avoid this complicating factor;
- 5 - finally, remember Lederle's Glycerinated Pollen Antigens offer the important advantages of stability, bacteriostatic properties and minimal reactions.

We will be glad to hold a "council of war" with you on difficult cases. Lederle's experience in the field of allergy spans a period of over a quarter of a century.

*Lederle*

**LEDERLE LABORATORIES, INC.**  
30 ROCKEFELLER PLAZA NEW YORK, N. Y.



*Timothy, Ragweed, Oak, Plantain and House Dust attack all 6 zones of the country. Others attack only some zones.*



# PROFESSIONAL LIABILITY PROTECTION

*Afforded Members of*

THE MEDICAL SOCIETY OF  
NEW JERSEY

*Since 1921*

**FAULHABER & HEARD, INC.**

Authorized broker to negotiate  
professional liability contracts for  
The Medical Society of New Jersey

CONSULT US

For Protection and Specialized Service

31 Clinton Street

Newark, N. J.

Telephone MITCHELL 2-1294

**FAULHABER & HEARD, Inc.**

**31 OLINTON STREET**

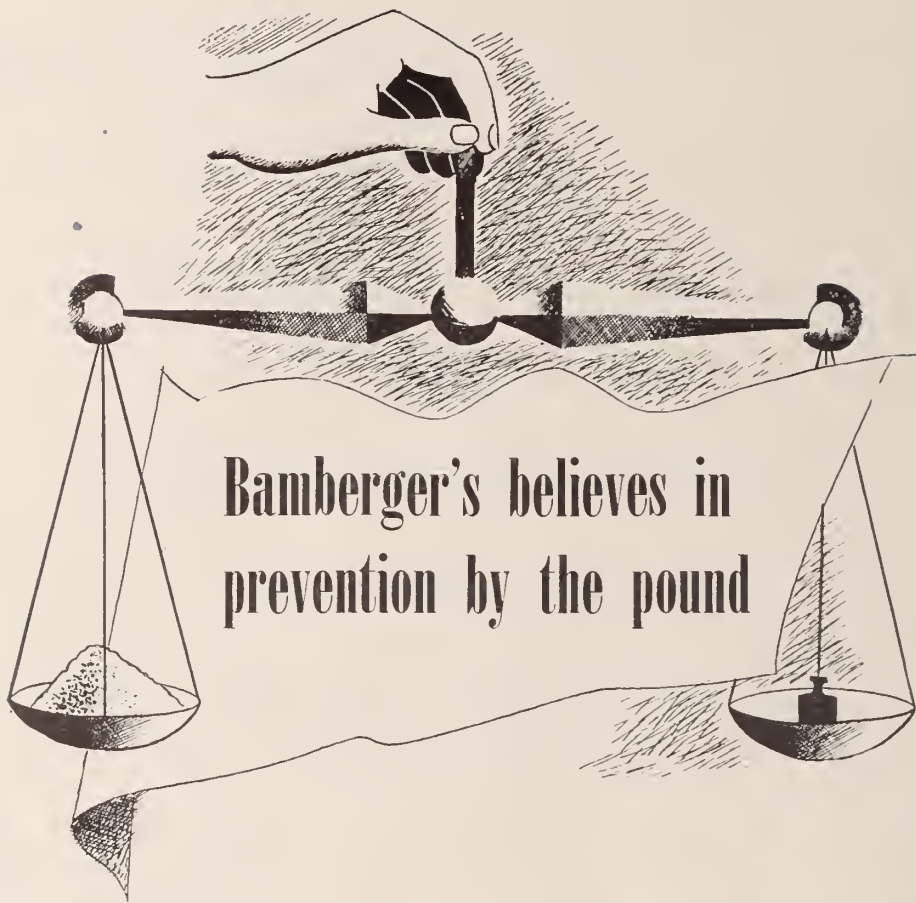
**NEWARK, N. J.**

Kindly send information on limits and costs of Society Professional Policy.

Name • .....

Address .....

.....



## Bamberger's believes in prevention by the pound

*Long before the Food and Drug Act of 1939, Bamberger's had enacted one of its own. From all the Bamberger brands in foods, drugs, cosmetics, and devices, Bamberger's Bureau of Standards had eliminated those ingredients known to be detrimental to health. In the case of a few national brands, Bamberger's has cooperated with the manufacturer in eliminating harmful ingredients. Then, as now, Bamberger's Bureau of Standards scrutinized advertisements and labels, to make sure the consumer received complete and accurate information. Bamberger's believes, as it has always believed, in safeguarding the health of its customers. Bamberger's believes in prevention, not by the ounce, but by the pound.*

**L. BAMBERGER & CO.**



"ONE OF AMERICA'S GREAT STORES"

\*Reg. U. S. Pat. Off.



## Why let a busy mother upset your formula balance?

**T**HE OPTIMAL NUTRITION which your baby feeding prescriptions provide... may be lost through errors in formula preparation.

For even the best-intentioned mothers may make mistakes in measuring. Or leave out important supplements. Or fail to follow instructions completely.

**Biolac makes such formula errors all but impossible, because:**

1. Formulas are made by simply diluting Biolac with water.
2. Biolac provides completely for *all* the nutritional requirements of early infancy except for vitamin C.
3. No supplementary formula ingredients are necessary.

Biolac is prepared from whole milk, skim milk, lactose, vitamin B<sub>1</sub>, concentrate of vitamins A and D from cod liver oil, and ferric citrate. It is evaporated, homogenized, and sterilized.

4. The adequate carbohydrate content of Biolac is processed in the milk, is in equilibrium and is sterile.

5. The nutritional completeness of Biolac is guaranteed by strict laboratory control of manufacturing operations and assays of product composition which are recognized in its A.M.A. Council acceptance.

Thus in prescribing Biolac you have these extra assurances that your babies will actually receive in their formulas the optimal nutrition you prescribe.

Biolac nutritional values equal or exceed recognized standards. For complete information, write Borden's Prescription Products Division, 350 Madison Ave., New York, N. Y.

*Visit Our Booth No. 13 at the Atlantic City Meeting*



# Borden's BIOLAC

A BORDEN PRESCRIPTION PRODUCT







A HYDROCHOLERETIC  
FOR THE EFFECTIVE  
TREATMENT OF MANY  
DISORDERS OF THE  
BILIARY TRACT

FLOW INCREASED  
BY  
**CHOLAN-DH**  
2000 - 4500 CC  
BILE OF LOW VISCOSITY

NORMAL DAILY  
HEPATIC SECRETION  
1000-1500 CC BILE

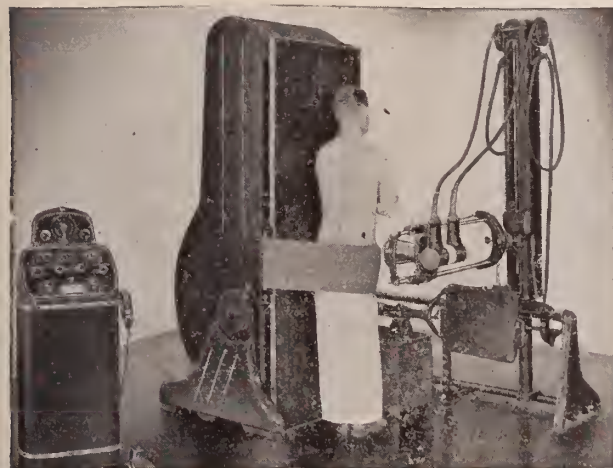
Comprehensive Literature will be mailed on request.

**THE MALTBIÉ CHEMICAL COMPANY**  
NEWARK, NEW JERSEY

# Congratulations, Doctor...

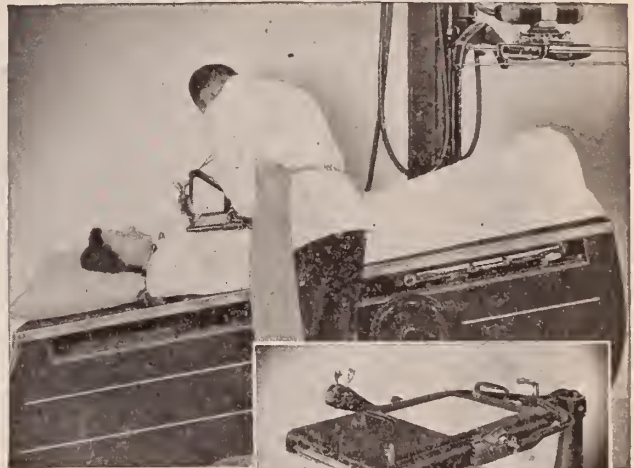
Since you've installed the Advanced "Series 200", we are producing radiographs that are "tops" in speed, detail, contrast!

The Picker-Waite "Series 200" is a complete diagnostic x-ray unit for radiography and fluoroscopy in any position. Speed, precision and ease of operation are inherent features of the "Series 200".

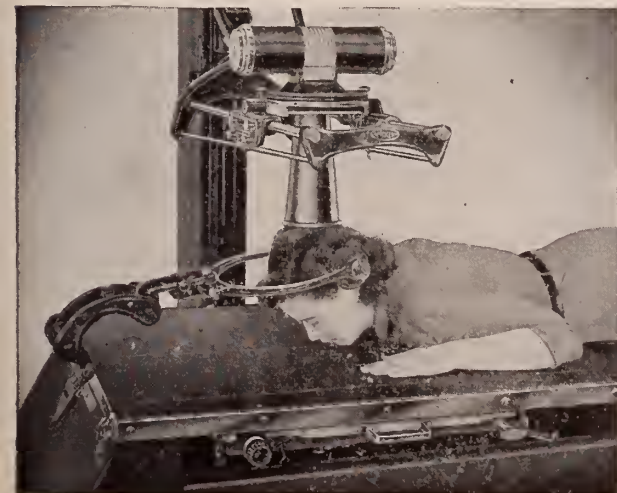


THE "SERIES 200" delivers 200 milliamperes over and under the table.

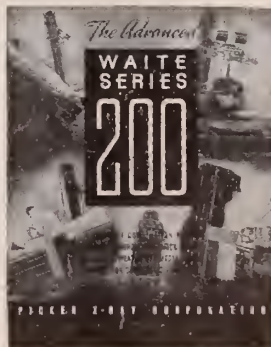
X-Ray exposures of the lateral pelvis or spine in  $1\frac{1}{2}$  seconds and 6 foot chest films in  $1/20$ th of a second are routine procedure.



WITH ITS SPOT FILM ATTACHMENT, the "Series 200" is ideal for gastrointestinal examination.



**SINUS AND SKULL WORK** is easily achieved—and with complete comfort to the patient. An adjustable head clamp (optional) facilitates positioning and insures immobilization.



**PICKER X-RAY CORPORATION**  
300 FOURTH AVENUE  
NEW YORK, N.Y.

Gentlemen:

Please send your complete bulletin on the Picker-Waite Advanced "Series 200" Diagnostic X-Ray Equipment to:

Dr. ....

Address .....

City .....





While at the  
Convention Visit  
Booth **33**

BE SURE TO  
SEE THE NEW

## HANOVIA AERO-KROMAYER LAMP AIR-COOLED

This supremely improved air-cooled Kromayer lamp is especially designed for local application of ultraviolet irradiation. The Burner housing is COOLED BY AIR instead of water, using new principle of aero-dynamics; no kinking of water tubes, no water stoppage, no overheating, no necessity for cleaning of water system. It has a more concentrated light source and gives more ultraviolet through applicators. The burner operates in every position and delivers a constant ultraviolet output. Automatic, Full-Intensity Indicator. Side emission applicators. It has many uses in every doctor's office and its frequent use more than repays its original cost.

Hanovia also makes the Luxor "S" Alpine Lamp, the Super "S" Alpine Lamp—Sollux Radiant Heat Lamps and Short and Ultra Short Wave D'athery equipment.

Complete information on all Hanovia Apparatus furnished upon request.



**HANOVIA CHEMICAL & MFG. CO. NEWARK, N. J.**

Dept. 332





**Q.** I've heard that canners just use the surplus crops. Is that true?

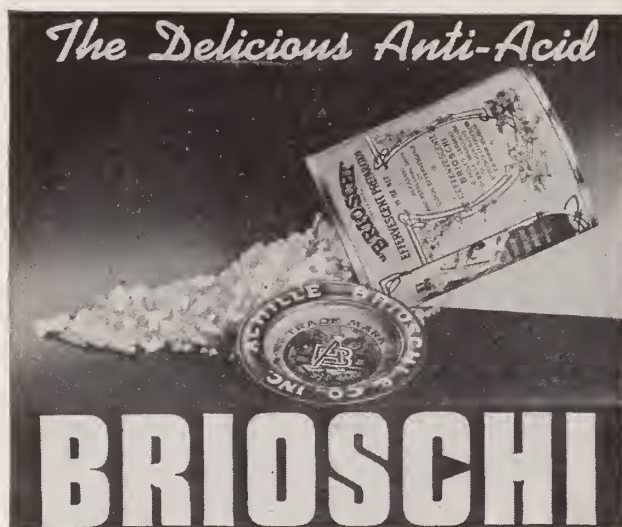
**A.** No. As a matter of fact, many of the varieties used for canning can not be obtained in any other form. Most canners contract for their crops for canning, months in advance. They usually specify the variety of fruit or vegetables wanted. And in many cases this means furnishing seeds or plants especially developed for their purposes. (1)

American Can Company, 230 Park Avenue, New York, N. Y.

- 
- (1) 1939. Agr. Expt. Sta. Univ. Wisconsin, Bul. 444.  
1939. Univ. Maryland Agr. Expt. Sta. Bul. 425.  
1937. U. S. Dept. Agr. Farmers Bul. 1253.  
1937. Univ. Illinois Agr. Expt. Sta. and Extension Service in Agr. and Home Econ. Circular 472.  
1929. Univ. Maryland Agr. Expt. Sta. Bul. 318.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

**BRIOSCHI A PLEASANT ALKALINE DRINK**

Actively alkaline. Contains no narcotics, no injurious drugs. Consists of alkali salts, fruit acids, and sugar, and makes a pleasant effervescent drink.

SEND FOR A SAMPLE

**G. CERIBELLI & CO.**

121 VARICK STREET

NEW YORK

**75 YEARS OF SERVICE TO CHEMICAL USERS**



Congress, under a joint Resolution of July 27, 1866, provided that each of the states be furnished with a complete set of weights, running from 10 kilograms to 1 milligram . . . unvarying throughout the states.

***Unvarying Standards***

As unvarying as Government standards . . . are the standards which rule the manufacture of Mallinckrodt Chemicals. Potentiometer, centrifuge and flask—the most modern scientific equipment available, in the hands of capable technicians—certify the potency, purity, and uniformity of Mallinckrodt Chemicals for medicine, pharmacy, industry, laboratory and photography.

With the experience of 75 years of manufacture

of fine chemicals as a guide . . . and a better knowledge of the requirements of each type of chemical user . . . Mallinckrodt Chemical Works stands ready and able to offer even superior service in the years to come. Research continues to be a fundamental Mallinckrodt policy. As in the past, our laboratory workers will continue to improve available chemicals and to add new, valuable products to the Mallinckrodt list of over 1,500 useful chemicals.



**MALLINCKRODT CHEMICAL WORKS**

*Serving Chemical Users for Seventy-five Years*

NEW YORK  
CHICAGO

ST. LOUIS  
MONTREAL

PHILADELPHIA  
LOS ANGELES

Only One  
Pair of  
Feet



in the World  
Could make  
These  
Prints



No other footprints are exactly the same as those of this newborn infant. And no other oxytocic product duplicates Pitocin,\* which helped bring this baby into the world. Pitocin contains the oxytocic principle of the pituitary gland with almost none of its pressor principle. Thus, it effectively stimulates uterine contractions without raising the blood pressure . . . an especially useful factor when labor is complicated by such conditions as nephritis and hypertension.

Pitocin is a familiar product in most delivery rooms. Obstetricians are pleased with its oxytocic reliability, its speedy action, the rarity of systemic reactions following its use. The Parke-Davis label assures accurate standardization.

Chief indications for Pitocin (alpha-hypophamine) are: medical induction of labor; stimulation of the lagging uterus during labor; prevention and minimizing of postpartum or late puerperal hemorrhage; and of blood loss following cesarean section or curettage. Literature on request.

\*Trade Mark Reg. U. S. Pat. Off.

# PITOCIN

A product of modern research offered to the medical profession by

**PARKE, DAVIS & COMPANY DETROIT, MICHIGAN**

OVER 75 YEARS OF SERVICE TO MEDICINE AND PHARMACY



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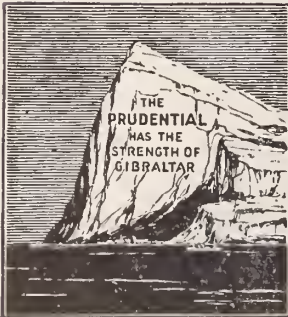
# Think of === Tomorrow!

*The man who first said "tomorrow never comes" was sadly misinformed.*

*Tomorrow is as inevitable as rising tide and setting sun.*

*And unless you provide against its uncertainties, you are making a major mistake.*

**PROTECT---with Life Insurance.**



**The Prudential**  
**Insurance Company of America**

Home Office, NEWARK, N. J.

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# KEEPING THE AIRWAYS OPEN



## TOPICAL NEO-SYNEPHRIN HYDROCHLORIDE

(laevo-alpha-hydroxy-beta-methyl-amino-3 hydroxy ethylbenzene hydrochloride)

### DOSAGE



### FORMS



**SOLUTION**  
1/4% in saline solution (1/2-oz. and 1-oz. bottles). 1% in saline solution (1/2-oz. and 1-oz. bottles). 1/4% in Ringer's Solution with Aromatics (1/2-oz. and 1-oz. bottles).



### JELLY

1/2% in collapsible tube with applicator.



### The NASALATOR

A convenient, vest-pocket applicator for Neo-Synephrin Solutions.

# FREDERICK STEARNS & COMPANY

NEW YORK  
WINDSOR, ONTARIO

DETROIT, MICHIGAN  
KANSAS CITY

SAN FRANCISCO  
SYDNEY, AUSTRALIA

# Belle Mead Sanatorium

Belle Mead

New Jersey

*Under State License Since 1910*

Sanatorium Phone

BELLE MEAD, N. J. 21

● For the individual care and modern treatment of nervous, mental, alcoholic, drug patients and general invalidism.



Full Cooperation  
With Referring Physicians



Rates Very Reasonable for  
Attractive Accommodations



J. C. KINDRED, M.D., *Consultant*

L. R. HARRISON, M.D., *Consultant*

MASON PITMAN, M.D.

E. A. SCOTT, M.D.

*Medical Directors*





## *Highly practical* for **INFANTS and CHILDREN**

**I**NCORPORATING the daily dose of vitamin D in milk removes some difficulties in administration. The mother merely needs to add the prescribed dose to the daily ration of milk. Moreover, biologic and clinical investigations have shown that when vitamin D is thoroughly diffused in milk smaller doses may suffice for the prevention and cure of rickets.

Drisdol in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. Unlike oily preparations, Drisdol in Propylene Glycol diffuses readily in milk and when well diluted imparts no taste nor odor.

#### HOW SUPPLIED:

Drisdol in Propylene Glycol—10,000 U.S.P. units per gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.



## DRISDOL

Reg. U. S. Pat. Off. & Canada

Brand of CRYSTALLINE VITAMIN D  
from ergosterol



### IN PROPYLENE GLYCOL

**WINTHROP CHEMICAL COMPANY, INC.**

*Pharmaceuticals of merit for the physician*

NEW YORK, N. Y.

WINDSOR, ONT.

## Don't Worry Too Much About This Shortage



A LARGE PORTION of this nation's Belladonna supply was formerly imported from the European countries whose shipments to our shores have now ceased. Atropine and Belladonna have since become extremely scarce—in many sections of the United States costs have reached rather high levels.

Fortunately, however, there need not be too much concern over this shortage. Syntropan the 'Roche' synthetic, non-narcotic antispasmodic is being produced in adequate quantities and is available to the entire medical profession. Many physicians consider the action of Syntropan 'Roche' superior to that of Atropine or Belladonna, and of much importance, the use of Syntropan affords greater *safety*—less likelihood of mouth dryness, mydriasis, or tachycardia. In other

words in relation to its activity Syntropan 'Roche' is less toxic than Belladonna and its derivatives.

Try Syntropan in the place of Atropine or Belladonna, to effectively control smooth-muscle spasm—in *spastic disorders of the cardiovascular system* such as arterial spasms, angina pectoris, and effort syndrome; in *gastro-intestinal disorders* for the relief of spasms due to hyperacidity and peptic ulcer, and pylorospasm; and in *uro-genital disorders* for the relief of spastic states of the bladder and ureter musculature. One 50-mg. Syntropan tablet in the place of 1/120 gr. (0.5 mg.) of Atropine Sulfate is recommended. Packages: Oral tablets (50 mg. each) in tubes of 20 and bottles of 100; 1cc ampuls (10 mg. each) in boxes of 6.

HOFFMANN-LA ROCHE, INC., NUTLEY, N. J.

Hoffmann-La Roche, Inc., Nutley, N. J.

Gentlemen: I should like to receive a professional sample of Syntropan, the 'Roche' synthetic, non-narcotic antispasmodic.

Dr. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Try

SYNTROPAN

'ROCHE'

The Better Antispasmodic

# What better proof of Philip Morris superiority:—

**E**VEN *more* conclusive than the obvious improvement in patients' conditions\* on changing to PHILIP MORRIS cigarettes is this:

**ON CHANGING BACK TO  
OTHER CIGARETTES,  
CONGESTION RETURNED  
IN 80% OF THE CASES.\*\***



# PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.

119 FIFTH AVENUE, NEW YORK, N. Y.

\* Irritation of the nose and throat due to smoking.

\*\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154.



# MECHOLYL CHLORIDE

Trade Mark—Reg. U. S. Pat. Off.

(Acetyl-Beta-Methylcholine Chloride Merck)

administered by the method of Ion Transfer  
(Iontophoresis)

*Council*  *Accepted*

Of service in the treatment of  
Vasospastic Conditions of the Extremities  
Chronic Ulcers—Raynaud's Disease  
Scleroderma—Chronic Rheumatoid Arthritis

*Literature on Request*



## ION TRANSFER — TECHNIC OF APPLICATION



Reinforced asbestos paper applied



Electrode placed over paper



Fully bandaged

MERCK & CO. Inc.,

*Manufacturing Chemists*

RAHWAY, N. J.

# No "Hit or Miss"

When you refer your patient to your colleague, the Eye Physician, for an Eye examination—your patient is in the hands of one qualified to treat and prescribe and one not interested in the sale of eyeglasses—and you too will receive a report of your patient's condition.

The SAFE WAY is the best way. Remember: Your colleague the Eye Physician for the examination and the Guild Optician to make the glasses, if any are necessary.



## Guild of Prescription Opticians of New Jersey, Inc.

ASBURY PARK  
ANSPACH BROS.  
552 Cookman Ave.

ATLANTIC CITY  
FREUND BROS.  
1006 Pacific Ave.

CAMDEN  
PELOUZE & CAMPBELL  
116 N. Broadway  
J. E. LIMEBURNER Co.  
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277 N. Broad St.

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FRED G. HOFFRITZ  
30 Park Place

HACKENSACK  
HOFFRITZ & PETZOLD  
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J. C. REISS  
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CHARLES STEIGLER  
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J. E. COLLINS  
241 Market St.

PLAINFIELD  
GALL & LEMBKE  
633 Park Ave.

SUMMIT  
ANSPACH BROS.  
212 Bassett Building  
H. C. DEUCHLER  
344 Springfield Ave.

UNION CITY  
ARTHUR VILLAVECCHIA  
1017 Summit Ave.

WESTFIELD  
BRUNNER'S  
206 Broad St.

**To EYE PHYSICIANS:** *Your coöperation with a Guild Optician is a guaranteed protection for your patient and yourself.*

## KOROMEX DIAPHRAGM



### KOROMEX TRIP-RELEASE INTRODUCER

TIP TURNS  
ON SWIVEL

**Holland-Rantos**  
*Company, Inc.*

551 Fifth Avenue

New York, N.Y.



# The Middle Way

..... IN BISMUTH THERAPY

## BISMUTH ETHYLCAMPHORATE

After the intramuscular injection of 2 cc. of Bismuth Ethylcamphorate, a treponemicidal level is ordinarily reached in forty-eight to seventy-two hours. This speed of effectiveness lies between that of water-soluble bismuth salts, which are faster, and oil suspensions of bismuth salts, which are slower. Since this promptness of therapeutic action is coupled with good duration of effectiveness, Bismuth Ethylcamphorate possesses the advantages of the "middle way."

Sterile Solution Bismuth Ethylcamphorate is the bismuth salt of ethyl camphoric acid dissolved in sweet almond oil. It is available in boxes of six and twenty-five 1 cc. ampoules, and in 30 cc. vials.



*Fine Pharmaceuticals Since 1886*



# Nikethamide, Endo

*Nicotinic Acid Diethylamide*



The acceptance of NIKETHAMIDE by the Council on Pharmacy and Chemistry is a timely recognition of a wholly American-produced drug of importance.

A voluminous literature testifies to the frequent usefulness of Nikethamide in medical practice. The circulatory stimulating effects and analeptic action of this drug have proven often of value in anesthetic collapse and, indeed, in many instances of respiratory failure requiring emergency treatment.

NIKETHAMIDE, Endo, is supplied for parenteral administration in boxes of 12 and 100 ampoules of 1½ c.c. size; for oral use, in vials of 15 c.c.

*Literature on request*



**ENDO PRODUCTS, INC., RICHMOND HILL, NEW YORK**

## 54% of our customers are sent to us by doctors

● 54% of Walker-Gordon customers tell us they started taking Walker-Gordon Certified Milk upon the advice of their physicians.

One of the reasons why the medical profession recommends Walker-Gordon Certified Milk is this:

REGULAR  
MILK



WALKER-  
GORDON



*During cold months Walker-Gordon contains 60% more Vitamin A than regular milk.*

During the winter and early spring months when most doctors consider an adequate supply of

REGULAR  
MILK

COWS GET ORDINARY HAY



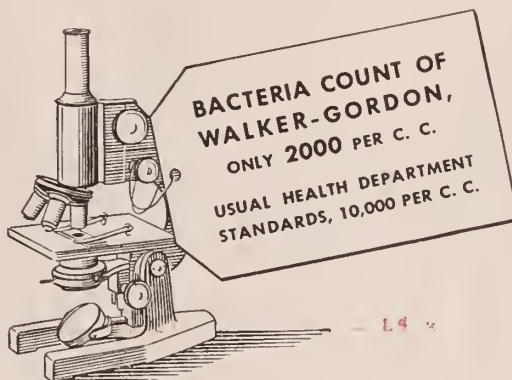
WALKER-  
GORDON

COWS GET SPECIAL  
SUMMER-RICH ALFALFA



Vitamin A most important, Walker-Gordon contains 60% more Vitamin A than regular milk.

The Vitamin A content is so high because the cows are fed a balanced ration of 16 foods—including dehydrated, summer-rich alfalfa rather than ordinary hay in the winter.



Another reason why doctors recommend Walker-Gordon Certified Milk is its exceptional purity.

Being produced entirely on our farm under the strictest sanitary control in the industry, the bacteria count of Walker-Gordon Certified Milk averages only 2000 per c.c. at time of bottling, compared to medical and health department standard requirements of 10,000 per c.c. Samples taken regularly from the bottling line show a complete absence of pathogenic bacteria.

# Walker-Gordon Certified Milk

THE WORLD'S FINEST MILK

AVAILABLE EITHER UNHEATED, PASTEURIZED, OR HOMOGENIZED





## THE ART OF DOING THINGS WELL

LILLY LABELS are *stamped by hand* to provide the all-important control number. Machine stamping is faster and cheaper, but on this job machines cannot match the accuracy of sharp eyes and nimble fingers. Without the number which identifies its lot, an ampoule, a bottle of tablets, or a box of suppositories is an orphan without family record. A Lilly product without means of positive identification is considered unfit for use.



*Eli Lilly and Company*

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U.S.A:

# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

Whole Number of Issues, 452

UNDER THE  
DIRECTION OF THE  
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor  
IN ACTIVE SERVICE A. U. S.

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Editorial and Executive Offices of the Society—143 East State Street, Trenton, N. J.; Tel. 5156

EXECUTIVE OFFICER AND ACTING EDITOR—LEROY A. WILKES, M.D.

EXECUTIVE ASSISTANT—NORMAN M. SCOTT, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

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VOL. 39, No. 4

APRIL, 1942

Single Copies, 30 Cents  
Subscriptions, \$3.00 per Year

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## ANNUAL REPORTS

In this convention number of *The Journal* appear the Annual Reports and the Annual Meeting Program. A supplement is being sent with the May *Journal* which contains the Official List of Members in good standing on the closing date for payment to the State Society Treasurer of County Society assessments for the dues year 1942.

In the Official List no member's name will be included whose dues were unpaid on March 15 as recorded on the assessment lists sent to the Executive Offices accompanied by proper checks for the Treasurer. If you are in service and are so certified by your County Society President and Treasurer, your dues are credited and your name appears in the Official List. If you are entitled to such consideration in accordance with the action of the Board of Trustees and your name does not appear in this list, you should see your County Society Treasurer and have the proper steps taken to con-

form to the procedure required by the Trustees' action.

As a matter of economy, and to conserve paper, as requested by the Federal Government, no separate issue of Annual Reports will be sent to the Delegates *for the duration*. Every member should read carefully the annual reports of the officers and committees as presented in *The Journal*. Each Delegate should bring his *Journal* to the Annual Meeting for reference.

Advisory Committee reports are reviewed throughout the year by the Sub-Committees to which they are assigned. The Sub-Committee reports are discussed and as approved are incorporated in the Welfare Committee report. Only the reports of Officers, Standing Committees and Special Committees and the Medical Service Administration will be reviewed by the Reference Committees at the Annual Meeting.

# Index to Annual Reports

## 1942

	Page		Page
Adult Health Supervision .....	201	Honorary Membership .....	185
A. M. A. Delegates .....	191	Hospital Relationships .....	209
Annual Meeting .....	195	Industrial Health and Hygiene .....	209
Auxiliary Medical Services .....	208	Judicial Council .....	188
Cancer Control .....	201	Legislation .....	198
Child Health .....	202	Maternal Welfare .....	204
Civilian Defense .....	215	Medical Care of the Indigent and Low-Wage Group .....	211
Conservation of Vision .....	203	Medical Defense and Insurance .....	191
Contract Practice .....	209	Medical Examiners, State Board of .....	217
Councilors .....	188	Medical Practice .....	200
County Societies, Reports of Presidents:		Medical Preparedness .....	213
Atlantic .....	219	Medical Service Administration .....	216
Bergen .....	220	Mental Hygiene .....	205
Burlington .....	221	Nursing and Nursing Education .....	212
Camden .....	223	Pharmaceutical Problems .....	212
Cape May .....	223	Pneumonia Control .....	205
Cumberland .....	224	Post-Graduate Education .....	195
Essex .....	224	President .....	185
Gloucester .....	226	President-Elect .....	187
Hudson .....	227	Prevention and Control of Heart Disease .....	206
Hunterdon .....	228	Procurement and Assignment .....	216
Mercer .....	228	Public Health .....	200
Middlesex .....	228	Public Relations .....	199
Monmouth .....	229	Publication .....	193
Morris .....	230	Scientific Exhibits .....	195
Ocean .....	230	Scientific Program .....	195
Passaic .....	231	Secretary .....	185
Salem .....	231	Traffic Accidents .....	206
Somerset .....	232	Treasurer .....	185
Sussex .....	232	Trustees .....	185
Union .....	233	Tuberculosis .....	207
Warren .....	235	Venereal Disease Control .....	207
Crippled Children .....	203	Welfare .....	196
Executive Officer .....	188	Woman's Auxiliary Advisory .....	192
Finance and Budget .....	185	Workmen's Compensation .....	212
Heart Disease .....	206		



# THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS TO THE HOUSE OF DELEGATES

April 21-23, 1942

The following will report directly to the House of Delegates:

President  
Secretary  
Treasurer

Finance and Budget Committee  
Honorary Membership Committee

## BOARD OF TRUSTEES

WILLIAM F. COSTELLO, M.D., Chairman, Dover

Your Board of Trustees reorganized May 22, 1941, and reelected Dr. Aldrich Crowe as Secretary and Dr. William F. Costello as Chairman. Up to the date of this preliminary report, five regular and three special meetings have been held.

Most of our activities have been confined to problems arising from the Medical Service Administration and Medical Preparedness Programs. In keeping with the policy of the administration, we have curtailed as far as possible all other activities in order to retrench financially where feasible, and to allow our Executive Staff as much time as possible for our two major activities.

The reports of both the Medical Service Administration and the Medical Preparedness Committee will cover their work so that we will not go into a detailed report in this presentation.

We have had many conferences in reference to the Medical Service Administration and authorized their action in collaborating with the Hospital Plan of New Jersey whereby the Hospital Plan would sell our contract to hospitalized patients. The question of removing the income "ceiling" was referred to a special conference of the House of Delegates at which time the sense of that conference seemed to be that it was advisable to remove the income ceiling, and your Board of Trustees accordingly approved that action.

Since that meeting, we are informed that further change in the schedule of charges to be made must be put into effect and is a matter for our discussion at the next meeting of the Board of Trustees.

We wish to take this opportunity to commend to the House of Delegates the activities of the Board of Governors of the Medical Service Administration. They have had a tremen-

dous job in putting this matter into shape and have necessarily been compelled to make many changes. During all this time they have worked patiently and industriously. It is the feeling of the Trustees that this group has earned a definite vote of thanks from the House of Delegates.

The Medical Preparedness Committee have had few problems which they could not solve themselves, which they referred for our routine approval. Dr. Norman M. Scott is still working with them and his retention as Executive Assistant, loaned to both the Medical Service Administration and the Medical Preparedness Committee, has been approved for another year.

A leave of absence has been granted to Dr. Henry A. Davidson until the expiration of his term of office in June, and his work is being carried on by our Executive Officer. We recommend that this policy be continued for another year. We feel that in so doing the standard of *The Journal* can be maintained and a definite saving made in the budget.

During the past year we have printed in *The Journal* an abstract of the important items taken up by the Trustees in the hope that the membership may be kept more closely informed on the events transpiring during the year.

The following is a list of the more important activities during the year:

July 27, 1941.

Adoption of policy in regard to the Bureau of Industrial Hygiene as follows:

*Whereas*, Industrial Health and Hygiene is essentially a problem of preventive medicine;

*Be It Resolved*, That it is the sense of this conference that a Bureau of Industrial Health and Hygiene be established,

that in the personnel of such a Bureau there shall be proper medical representation approved by The Medical Society of New Jersey, and that the Bureau shall be available to provide consultative services to any organization, State Department, or authorized individual who shall request such services.

Approval of date and plans for Annual Meeting.

Action in reference to remission of dues of men in active military service.

*Whereas*, The House of Delegates has approved the principle of paying from the surplus that part of the assessment against the County Societies due on account of members in active service with the armed forces of the nation, it is ordered by the Board of Trustees that an account in the amount of \$3500.00 be set up in the surplus fund, to be called the assessment credit, against which charges may be entered in the following manner:

*Whereas*, For every member certified by the President and Secretary of a County Society to have been in active service on March 31st, 1941, a charge of \$16.00 shall be entered against the above credit; for every additional such member on June 30th, a charge of \$12.00; and similarly on September 30th and December 31st, charges of \$8.00 and \$4.00 respectively.

The Treasurer of this Society, being satisfied that the pro-rata assessment for such member or members has in fact been paid to him by the respective County Treasurers, shall refund to said County Treasurer the amount of the charge thus established, but if the assessment in question has not been actually paid, then the amount shall be credited to that County as assessment paid.

*September 21, 1941.*

Approval of action of the Medical Service Administration in coöperating with the Hospital Plan of New Jersey in the sale of Plan

2 and also approving the action of removing income ceiling and of basing remuneration on the basis of hospital accommodation of the patient.

Approval of appointment of Dr. Charles Schlichter as Chief of Emergency Medical Service with Dr. Norman Scott as Associate.

Passage of resolution making the Executive Officer responsible for all exhibit arrangements and for all committee assignments in connection with exhibits. This will remove all cause for duplication and increased cost.

At request of Legislative Committee, Dr. Frederic J. Quigley was reappointed Executive Secretary of that Committee at same salary.

*October 26, 1941.*

Approval of changes in Medical Service Plan and recommendation to House of Delegates for its adoption.

Authorization of transfer of moneys already appropriated to the Medical Service Administration.

Continuation of Dr. Norman Scott as Executive Assistant to The Medical Society of New Jersey.

*January 25, 1942.*

Approval of report of Annual Meeting Committee.

Appointment of Dr. Andrew McBride as Trustee member of Finance and Budget Committee.

Approval of agreement between Medical Service Administration and Hospital Plan for operation of Plan No. 2.

Approval of plan whereby physicians may participate in rehabilitation work.

A meeting is to be held March 22nd at which many matters of importance will be discussed and will be reported in a supplemental report at the Annual Meeting.

The Board of Trustees wish to take this opportunity to express to the Chairman and members of the various Committees their appreciation of their efforts to coöperate with the program of the Administration during the year, and to commend the Executive Staff for a most coöperative spirit in all our activities.

## PRESIDENT-ELECT

ELIAS J. MARSH, M.D., Paterson

Your President-Elect has to report that, in the three years of his vice-presidency (for, both traditionally and practically, they amount to that) he has visited each of the twenty-one county societies once, as the official representative of the President, and some of them several times, on various special occasions. This has been for him a most gratifying experience, enjoyable personally and socially, stimulating professionally, besides increasing his knowledge and his pride in his native State. The benefit to either the state or the county societies from the contacts thus made is more difficult to appraise: undoubtedly it would be greater if the contacts could be more frequent and the exchange of ideas freer, but even within the present restrictions enough advantage accrues to make the custom worth while. In several of the larger counties the experiment of meeting with the Executive Council was tried, instead of with the general society. This had the advantage of facilitating exchange of thoughts, and of stating the President's message in the most effective way, but at some cost through loss of contact with the general membership. Perhaps a plan may be evolved for combining the two approaches.

It has long been the custom of certain counties to hold occasional joint meetings with neighboring societies, or to be formally or informally represented at adjoining county meetings. My recent experience leads me to believe that much might be gained if every county were to send occasional delegations of goodwill, not only to adjoining counties but to distant ones; Cumberland to Bergen, for instance, and Passaic to Ocean or Cape May. I am sure the visiting delegates could learn much, and the hosts develop a more neighborly feeling toward distant colleagues. With the threatened wartime curtailment of travel, this may not be immediately practicable, but I suggest the plan for consideration.

And now a few words about the office of President-Elect itself. Having observed this somewhat anomalous office since its first ap-

pearance in our Society, less than ten years ago, and having occupied it for a term, the present holder recommends its abolition, with the return to our former custom of three vice-presidents and a regularly elected president. The title "president-elect" came among us through adoption of A. M. A. terminology, without the justification of A. M. A. conditions, or the consistency of A. M. A. procedure. In the A. M. A. system, no vice-president or other officer, no delegate, is eligible for the presidency. To offset the disadvantage of having a president who would probably know nothing of the mechanism of his organization, they elect their president a year before the beginning of his term, to allow him the opportunity of learning by observation. By common usage applying to any officer between election and induction, he is the president-elect, but is not an officer of the association, nor has any status beyond that of a privileged observer, and, of course, the prestige of his position. At the end of his year of pupilage, he is inducted into the presidency, whatever may have happened in the interval.

With us, it is different. By immemorial custom, our third (recently *called* second) vice-president is in effect the president designate of three years afterward. For well over a century, the person so designated has failed to reach the presidency only in very rare instances, all but one due to resignation or death. In one single instance has the presidency been refused to a first vice-president, and while I was personally opposed to the action then taken, I think it proper that the Society should have the power to do it: today it has not that power. On the other hand, only one president has been chosen without vice-presidential experience, and he had been chairman of the Welfare Committee. Moreover, it seems doubtful whether any president of this Society has been elected to that office since 1933. Our present procedure is to *elect a president-elect*, who, after a year in that office, glides, melts, or fades away, into the presidency. I recommend to the Society a re-study of this procedure.



## JUDICIAL COUNCIL

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CHRISTOPHER C. BELING, M.D., Chairman, Newark

Another year has passed without the Judicial Council being called upon to consider any matters of an ethical or judicial character.

### FIRST DISTRICT

Union, Warren, Morris and Essex Counties

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CHRISTOPHER C. BELING, M.D., Newark

The component societies of this district have maintained the same high standards of medical ethics and scientific work. No problems needed the attention of the Judicial Council of the First District during the past year.

### SECOND DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

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VINCENT P. BUTLER, M.D., Jersey City

There is nothing to report as there have been no matters requiring the services of the Council of the Second Judicial District.

### THIRD DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

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BARCLAY S. FUHRMANN, M.D., Flemington

Your Councilor for the Third District reports that he has had no calls this year either from any society or any member. He believes this shows a prosperous condition in the district.

### FOURTH DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

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S. EMLÉN STOKES, M.D., Moorestown

There have been no problems reported to the Judicial Council for the Fourth District calling for action, which indicates prevailing harmony. There has been no need for my services during the year, but I assure the officers and members of each County Society in this district of my interest in their work and willingness to serve them whenever called upon.

### FIFTH DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

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CHESTER I. ULMER, M.D., Gibbstown

There will be a Fifth Councilor District Meeting in Atlantic County on March 13, 1942, sponsored by the Atlantic County Medical Society. An interesting program has been arranged and we are looking forward to a successful affair.

The Councilor has urged that a District Meeting be held every year. We feel that they promote a spirit of fellowship among the members and tend to increase the solidarity of our State organization.

No cases of malpractice were brought to our attention in the past year.

## EXECUTIVE OFFICER

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LEROY A. WILKES, M.D., Trenton

The Medical Profession in New Jersey and elsewhere in the last decade has sought to preserve what its members believe to be a generally satisfactory type of professional medical service to their patients, rich and poor alike, and with few exceptions their reward has been chiefly a comfortable living for themselves

and their families, and the professional satisfaction resulting from an honest and intelligent effort to prove worthy members of their great profession.

In the last decade a demand has been voiced by groups and individuals within and without the profession for *better methods of distribu-*

tion of these professional services, and better distribution of the cost of medical care. It is worthy of note that this demand is for more service, which in itself is a mark of approval and commendation of the professional aspects of the medical care now available.

Your Executive Officer has, during his incumbency, continually studied what was being done in New Jersey by our members, and elsewhere, and has tried to assist the officers and committees in their constant efforts to improve the professional standards and maintain the ethics of the members of the Society, as they felt these aims might best be achieved.

The aim of the executive is to assist, by use of well-established business methods, in the accomplishment of the stated aims and objectives of the Society. I think it fair to say that something has been accomplished in this effort during each year. The methods of distribution are already being markedly affected, chiefly by government, as a result of (1) the change in philosophy and function of government, and (2) the war.

There is no more democratic organization in New Jersey than The Medical Society, which began in 1776 as a "brotherly association" of physicians, and to all intents and purposes has remained fundamentally the same. Service to individuals on individual agreements, and on an individual fee basis is possible under this form of organization, but service to individual members of selected groups, paid for through monthly premiums, which can be budgeted, is a new experience to medical practitioners, and is receiving increasing attention. Such experiments must maintain quality of service and make the cost more easily borne. This problem is urgent and needs constant study.

The Medical Service Administration is one of many similar experiments which has been further complicated by the outbreak of war in our country. This study and experiment needs not only the approval and support of every member if it is to succeed, but also needs the suggestions and help of those who participate as subscribers, physicians and administrators of such service agencies approved by the profession. Facts are needed to replace opinions, other than professional. This experiment has cost considerable, and more funds will be needed until the benefits of a large number of subscribers make it self-supporting. The alternative seems to be some form of indemnity fund such as the Hospital Service Plan had under consideration, and which was first approved by the A. M. A., as the most practical in application.

Group service agreements with State and

Local Government agencies such as E. R. A., State Board of Children's Guardians, State Department of Health, Bureau of Maternal and Child Health, have already increased physicians' participation in and income from group medical services. This organized effort can be further extended. It is a comparatively new field.

A study of the Welfare Committee's recommendations of the last few years shows many of these recommendations now being carried out by government agencies such as schools and others who deal with groups. Industry is also seeking group medical service agreements, at a price they can afford, and which insure basic medical services. What should be included in basic medical service—certainly not a private room and bath or a private nurse in every case. A ward bed, a bed pan and the ward nurse cover satisfactorily the real adjuncts which are essential to the doctor in his care of most of his patients. There are other essentials in the exceptional case. Auxiliary services such as x-ray and laboratory tests are of course essential to proper diagnosis. What basic services can be assured to all members of a group when, as and if needed, at a reasonable monthly rate if paid regularly, preferably by pay-roll deductions. Such studies and definitions are badly needed and will become increasingly pressing for solution.

Medical care is needed now more than ever. Possibly we can increase our service to patients and our return, by employing technicians as do the hospitals. A group of needed and approved technicians can be employed to serve a group of physicians whose offices are in the same building, preferably on the same floor, or who have the same offices at different hours. Doctors can then employ the time now spent rewrapping a dressing, giving hypodermic injections, recording data, etc., much more professionally and profitably if these technicians are directed and told to do things we know they can be trained to do, as well as we, and at less cost.

The Executive Staff of The Medical Society of New Jersey has no "power", and any authority it may have is specifically granted to it by the Executive Board (Trustees) who control its services. The centralization of the mechanism of the Society and its reports and full-time personnel in no way centralizes authority, but provides the most efficient and economical organization to further the aims and objectives set by the duly elected officers and committees. Such an organization provides flexibility of staff personnel to meet the varying demands made upon its various services.

This has been pointed out on previous occasions.

The trends of the last decade have shown an unmistakable shift toward organized effort—even in the medical profession where the organized effort is made to preserve individual liberty and freedom from outside attack. Changes have been made, and further changes seem to be likely in the future, to improve the distribution of services—especially for the indigent and very low-wage groups who cannot pay for private individual medical services. The Medical Society itself is making preparations to meet these changes as they occur, with least sacrifice of fundamental policy or principle. We believe that New Jersey is better organized for this purpose than many other State Societies and the esprit de corps is commendable. The integration of effort of the Officers and Committees in both State and County Societies has decidedly improved in the last decade and we face the crisis ahead with calm confidence and solidarity. The need for economy is recognized and there is probability that some curtailment of activities is likely as Government invades all functions in the State, including medical practice. On the other hand, wages and demands are increased and the number of physicians called into Federal Service and industry has already depleted our ranks. This number will increase still further in the next year. The Executive Offices will be helpful in keeping the members remaining in the State apprised of developments as they occur or affect medical practice. These changes will be periodically discussed and the decisions reached by Officers and Committees will be sent to County Society Officers and printed in *The Journal*, which is an official Society "organ" as well as a scientific journal. The State Defense Council; the Procurement and Assignment Office and the Selective Service Agency are now becoming better organized and the load on the practicing physicians in the work of these organizations has lessened until an actual invasion appears imminent or definitely occurs.

The scope of function of individual physicians and the medical profession as a whole is professional care. Within this scope they excel, but the tendency is to exceed this proper

scope of function. To do this successfully requires further training and experience in other fields in which few practitioners have thus far become competent. To compete successfully with specialized non-medically trained personnel who devote their entire time in the field of distribution of service and the costs thereof, physicians would have little time to devote to their medical practice for which they have been trained through the years at a great cost to themselves, and from which preparations the practitioners have a right to expect a reasonable return when their demonstrated ability is in demand by those who seek their help and advice. It is this proven ability rather than the M.D. degree which they earned in the medical school which attracts patients and insures professional satisfaction and security.

The costs of Medical Society functions need careful analysis and study. An apparently low expenditure is often most uneconomical when properly analyzed. A much larger amount of money may prove a justified expenditure when the results achieved are properly evaluated. Cost accounting is a very essential and money-saving investment of time and energy, if done by those trained in this special field, and then explained in terms easily understood by those not experienced in this procedure.

Clerical and stenographic assistance in the Executive Offices, especially when under competent supervision and direction, is a real economy, while the too extensive use of the time of our members is an expensive luxury which should be reserved for the establishment of guiding principles and policies.

The President, as Dr. Lahey, incoming President of the A. M. A., has rightly emphasized, is the titular head of the A. M. A. and should not be eternally bothered with detail and procedure after objectives are set and policies decided upon. The Executive Board and the Executive Officer, who is their instrument, are designated in the By-Laws as responsible for the laborious work and responsibility, ad interim, of the House of Delegates. Dr. Lahey said the President should be honored and not worked to death during his incumbency. Many will agree with this stand regarding our own State Society Presidents.



## DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

THOMAS K. LEWIS, M.D., President, Camden

*General Impression.*—Considering the enormous accumulation of material requiring attention, the business of the House of Delegates was transacted with a minimum of confusion. The system of using reference committees for free discussion of controversial matters, such as has been in vogue in our own New Jersey Conventions, makes it possible for the Reference Committee to sense the attitude of the delegates so accurately that when final recommendations are presented to the House there is little necessity for prolonged debate. The meetings of the Reference Committees were reasonably well attended and, in them, no attempt was made to muzzle discussion. In one instance, at least, it was obvious that certain preconceived ideas of the Committee were radically changed as a result of the expression of opinions by interested delegates, with the result that when the matter under discussion came before the House the recommendations were passed, promptly, to the apparent satisfaction of the majority.

*Note*—This observation might well be given serious thought by the Delegates to our own Annual Meeting. For a number of years the attendance at meetings of our Reference Committees has been almost nil. When the battle is over, many go home with the idea that something has been "put over". The last meeting of the

House of Delegates is poorly attended in spite of the fact that it is at this meeting that all real action is taken and that commitments are made which will guide the officers of the Society in their activities for the year to follow. It is our opinion that no delegate should feel free to play truant at this last meeting unless he has made certain that the recommendations of all of the Reference Committees truly reflect the philosophy of his County Society.

The one outstanding action of the House of Delegates was that of the creation of a section for the benefit of the general practitioner. It was pointed out that most of the subject matter presented at the scientific meetings was pabulum for the specialist and that even the section on medicine was devoted to scientific minutiae that did not help the practitioner in the treatment of his patients. It was further proposed and recommended for advised consideration that a Board of Certification be created for the general practice of medicine. Attention was called to the fact that, in recent years, organized medicine had been stressing the all-important place of the general practitioner in American Medicine but that, at the same time, as a result of the activities of the Boards of Certification, general practitioners were being placed on a lower plane and, in some States, had actually been excluded from Hospital Staffs.

## STANDING COMMITTEES

### MEDICAL DEFENSE AND INSURANCE

CHRISTOPHER C. BELING, M.D., Chairman, Newark

The Committee on Medical Defense and Insurance can only give a partial report of its work. It is probable that the final figures will not show an increase in the number of members insured in the special liability contract because quite a number of members have gone into the service. We have now approximately 90 per cent of the members carrying the contract.

To meet the emergency situation, an arrangement has been made with the Insurance

Company for the cancellation of existing contracts on a pro rata basis for all those member who enter government service.

In the *Journal* of The Medical Society of New Jersey, December, 1941 issue, page 655, the Committee published information giving the views and decisions of the Insurance Company carrying malpractice insurance for the members of the Society.

It is advisable that no doctor surrender his professional liability contract prior to actual en-

trance into the service and not until after he has treated his last patient. It must be borne in mind that the statutory limit in this state permits a claimant to bring suit within two years following any treatment causing an alleged malpractice.

The Committee hopes that it may be able to supplement this report with the usual tables and discussions regarding the work of the year.

#### ACCIDENT AND HEALTH INSURANCE

This report covers the period from March 20, 1941, to February 1, 1942, somewhat less than eleven months.

Fifty new policyholders were added, but quite a number were lost due to entrance into the armed forces of our country. This left but a small net gain in the number of policyholders previously in force on March 20, 1941.

During the year forty-five claims were paid to disabled policyholders ranging in amounts from \$23.00 up to \$700.00. Unsolicited testimonial letters received by the Company during the past year speak well for the services rendered.

Another year has gone by during which time no claim was in dispute that required the arbitration of our Committee. For the past four

years no claim has been submitted for arbitration.

During the past year a non-cancellable Agreement Rider was officially approved by the Insurance Department. Mention must be made of the reduction in the premium for those between the ages of 50 and 65 in the Physicians Special Policy, effective as of January 1, 1942. The reduction was approximately 5 per cent for ages between 50 and 60 and about 27 per cent between the ages of 61 and 65.

The financial statement of the National Casualty Company as of December 31, 1941, shows that the Company has \$1.68 of assets for every \$1.00 of liability.

The Committee wishes to thank Messrs. E. & W. Blanksteen for their invaluable services. The Committee also takes this opportunity to thank Mr. William N. Heard for his excellent services during the past year.

#### RECOMMENDATIONS

We recommend:

1. Renewal of the existing contract for Medical Defense through our official broker, Messrs. Faulhaber & Heard.
2. Renewal of the present contract on Accident and Health Insurance through Messrs. E. & W. Blanksteen, our official broker.

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## ADVISORY TO WOMAN'S AUXILIARY

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WILLIAM E. DODD, M.D., Chairman, Beach Haven

Mrs. Oswald R. Carlander, President of the Woman's Auxiliary; Dr. Thomas K. Lewis, President of The Medical Society of New Jersey, and the Chairman of this Committee held an informal meeting in Trenton in the late summer of 1941, at which time the program of activity of the Woman's Auxiliary for the year was discussed. Dr. Lewis urged the adoption of a five-point program to occupy the foreground in the programs of the various Auxiliaries. This was further discussed by the same group, to which Dr. LeRoy Wilkes was added a few weeks later. It was finally presented to the Auxiliary at their Fall Board Meeting held in Camden on October 13, 1941.

The five points were as follows:

1. Medical Preparedness.
2. The American Way of the Practice of Medicine.
3. Common Sense in Nutrition.

4. The Medical Service Administration.
5. The Hospital and Your Community.

This five-point program was in no way intended to detract from, or to supplant projects already undertaken, but was intended to be added to them.

The following response from the Auxiliaries has been forthcoming:

#### 1. MEDICAL PREPAREDNESS

Questionnaires were sent to all members of the Auxiliary asking information to be recorded on the various qualifications of its members in order that this valuable group of women might be used to the best advantage for National Defense. Over 400 questionnaires on the personnel of our Medical Auxiliary were returned and classified. Directions were given to each Auxiliary for their use, namely that these available resources should be made

known to the defense councils in the various communities where the survey was made.

## 2. THE AMERICAN WAY OF THE PRACTICE OF MEDICINE

Throughout our State representative physicians have spoken before various audiences upon this subject. The program of the Kiwanis Club is particularly noteworthy. The members of the Auxiliary, in their own influential way, have been of tremendous value in backing up their husbands in the defense of the private practice of medicine.

## 3. COMMON SENSE IN NUTRITION

A number of the County Auxiliaries, including Hudson and Essex, have had speakers on Nutrition. The State Board Meeting of the Auxiliary on March 9th, 1942, will have a speaker on this subject.

## 4. MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott spoke on this subject at the Reciprocity Meeting of the Atlantic County Auxiliary and the Woman's Club of Atlantic City before 200 people.

## 5. THE HOSPITAL AND YOUR COMMUNITY

The members of the Bergen County Auxiliary have offered their services to the three General Hospitals in the county in case of an emergency.

In all communities greater interest has been shown in local hospitals as the logical place to turn in case of disaster. The Woman's Auxiliary has done a great deal to awaken this interest.

Other projects, too numerous to mention, have been carried forward. Wherever an Auxiliary member is found you will find her a leader in some useful work.

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# PUBLICATION

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HENRY C. BARKHORN, M.D., Chairman, Newark

*The Journal* is oriented to two major objectives: (1) Providing a living text book of current medicine; (2) providing a house organ through which members may be kept informed of Society activities.

The educational function of *The Journal* has been carried on through 82 scientific articles, covering 311 printed pages. Every branch of medicine and surgery has been touched upon and no member could have read all these articles without having received thereby a post-graduate course in modern medicine.

The activities of the Society itself have been reported through 208 pages of State Activities, 53 pages of County Society Reports and 31 pages of Woman's Auxiliary notes.

Last summer two new departments were opened—Bulletin Board and Personal Items. This made it possible to give members advance notice of important meetings in other parts of the State. Because New Jersey is small in area, any doctor interested in a particular subject can reach a meeting anywhere in the State. For this reason the Bulletin Board has been a highly practical service to the readers. The Personal Items have proved highly popular and especially in times like the present, when changes of address and status are occurring every day, this page has, and will continue to have, a tremendous human interest value.

In the fall a new department—Letters to The Journal—was established. This makes the

channel between the Society Officers and its members a real two-way passage. It is thus possible not only for officers to communicate with members, but for members to communicate with each other and with the Society officials. The Letters to The Journal section also offers a forum for the discussion of scientific questions raised by the original articles.

In January a special section was established to collect in one place all of the material touching on the medical aspects of the war effort. Since Organized Medicine will have a prime rôle in the procurement of medical personnel for the Army and Navy, and in the promotion of the health aspects of Civilian Defense, it is certain that this "war section" will be exceptionally helpful to the profession and to the public.

Few changes have been made in format. The editorials have been set in larger and more readable type. The small type of the County Society Reports had to be retained for reasons of economy, but the copy was made more legible by placing all personal names in small capitals. Beginning with the January 1942 issue, Roman numerals were replaced by Arabic figures in the advertising section. The paper shortage may make it necessary to abandon the practice of mailing *The Journal* in wrappers—addressographed labels will be used.

*The Journal* is at the disposal of all committees and several of these have made wide use



of its facilities. The Maternal Welfare Committee has had an article in every issue. The Public Relations Committee usually provides a monthly editorial. We have published special sections for the Medical Service Administration, the Medical Preparedness Committee, the Workmen's Compensation Committee and the Traffic Accidents Committee. We have published special editorials and articles on behalf of the Committee on Pharmaceutical Problems. At the request of the Legislative Committee, a special editorial was prepared on "The Legislator and the Doctor" and at regular intervals *The Journal* has been sent to members of the Senate and the Assembly. *The Journal* will continue to extend this hospitality to all committees of the Society.

Agencies outside the Society which have a legitimate message for the doctors have been welcomed. Pages have been placed at the disposal of the State Board of Medical Examiners, the State Department of Health, the New Jersey Hospital Association and similar organizations.

In May, 1941, Dr. Frank Overton, who had been the Editor of *The Journal* for six years, resigned, and Dr. Henry A. Davidson was appointed as his successor.

#### ADVERTISEMENTS

Included among the advertising pages are those devoted to *Society Organization*, as follows:

The index of the reading pages, which appears on the first cover page of each Journal	12 pages
The list of officers and committees	24½ pages
Total	36½ pages

#### SUPPLEMENTS

February, 1941—Medical Service Administration	20 pages
April, 1941—Official List of Members	92 pages
August, 1941—Transactions	28 pages
Total	140 pages

#### RECEIPTS

From June 1, 1941, to March 31, 1942	
Turned over to Dr. Young, Treasurer	\$10,499.31
Estimated receipts to May 31, 1942	2,600.00
	\$13,099.31

#### EXPENSES

From June 1, 1941, to March 31, 1942	
Journal	\$10,779.37
Reprints	80.65
Estimated expenses to May 31, 1942	3,000.00
	\$13,860.02

Following is a table of distribution by pages:

	Original Articles	State Activities	County Society Reports	Woman's Auxiliary	Book Reviews*	Bulletin Board	Personal Items	Letters to The Journal	Total Reading Pages	Pages of Advertising Including Covers	Total Pages in Monthly Issues
1941											
January	29	18	7	3	2	..	..	..	62	38	100
February	24	8	4	3	3	..	..	..	46	38	84
March	25	13	5	3	..	..	..	..	50	34	84
April	32	6	7	4	1	..	..	..	52	36	88
May	..	86	..	..	..	..	..	..	86	74	160
June	15	15	7	5	1	..	..	..	46	34	80
July	26	5	5	..	1	1	..	..	42	38	80
August	28	4	1	1	3	1	..	..	42	38	80
September	46	3	..	2	3	1	..	2	62	34	96
October	30	16	6	1	2	1	..	..	60	40	100
November	25	14	5	5	5	2	1	1	62	34	96
December	26	20	6	4	2	1	..	..	64	36	100
Totals—1941	306	208	53	31	23	7	1	3	674	474	1148
Totals—1940	241	260	70	11	..	..	..	..	628	484	1112
Totals—1939	334	270	80	24	..	..	..	..	758	482	1240
Totals—1938	323	236	92	31	..	..	..	..	788	468	1256
Totals—1937	385	181	108	34	..	..	..	..	774	510	1284

\*In previous years the Book Reviews were included in State Activities.

## POST-GRADUATE EDUCATION

STUART Z. HAWKES, M.D., Chairman, Newark

During the year 1941-1942 the Committee on Post-Graduate Education functioned to follow the general plans laid down in previous years. In the spring of 1941 a postcard questionnaire was enclosed in *The Journal*, to determine the trend of requests for further teaching. It was thought that much useful directional information could be gained to help reach the needs of the average doctor. There were about 500 replies to this postcard, and the requests were uniformly for more clinical teaching throughout the state in each county. Because of world conditions, the desires discovered in this survey have not been put into record form or published in detail in *The Journal* because it was felt that the time was not opportune or space in *The Journal* warranted for such a report at the present time. However, the information is being saved and should be just as useful when the opportunity arises for its use at a later date.

We have had excellent coöperation between the committee and Dr. R. H. Light, who has the active charge of the medical work of the Rutgers University Extension Division. Courses have been given in only two centers this year, under this plan, with 150 doctors attending. These courses were in Morris, Camden and Gloucester counties. Other counties that have previously coöperated wholeheartedly felt that due to the war they could not conduct this type of course.

With timely Post-Graduate Education in mind, a recommendation was made to the Medical Preparedness Committee suggesting that courses be set up in each county on emergency surgery, as a part of civilian defense protection and education. Through the efforts of both committees, courses were given in a num-

ber of counties throughout the state, using either local speakers or those from neighboring centers. The courses in general have followed one set plan and have covered the following subjects:

1. General First Aid methods and casualty clearance.
2. Treatment of burns.
3. Treatment of hemorrhage and shock.
4. Treatment of fractures, splinting, traction splinting.
5. Transportation of the injured.
6. Treatment of blast injuries.
7. Protection against war gases.
8. Decontamination.

Essex County again ran four courses under the supervision of the New York University Medical College at the Newark City Hospital. Courses were conducted on gastroenterostomy, fractures, amputations, and peripheral vascular disease. While the enrollment was not as great as last year, it was better than had been expected.

With the present war all about us, it is the opinion of this committee that the Post-Graduate Education Committee should attempt to either improve the physician's knowledge of Civilian Defense measures or to better equip him to be of future use in the armed forces. This can be accomplished by instruction within the state, as well as by advertising national events of service to the individual doctors.

The Committee wishes again to express its appreciation to the Rutgers University Extension Division and to the many busy teachers and instructors who have given so freely of their time and efforts to help us in making this program a success.

## ANNUAL MEETING

J. CARLISLE BROWN, M.D., Chairman, Annual Meeting, Atlantic City  
WILLIAM W. HERSOHN, M.D., Chairman, Scientific Exhibits, Atlantic City  
CLARENCE L. ANDREWS, M.D., Chairman, Scientific Program, Atlantic City

The Annual Meeting Committee has arranged a program in accordance with the suggestions of the President and the schedule set by the House of Delegates at the last Annual Meeting.

The Scientific Exhibits, reduced in quantity probably due to war conditions, are, we believe and hope, of the usual quality.

The Scientific Program and the Sections have been discussed by the Annual Meeting Committee together with the Committee on Scientific Program.

We hope the program meets with the general approval of the members who attend the Annual Meeting.

## WELFARE

HILTON S. READ, M.D., Chairman, Atlantic City

Three meetings have sufficed this year for the Welfare Committee to consider the current problems coming within the scope of this representative body.

The original purpose of the Welfare Committee, to integrate the activities of the Society as a whole, and to serve in an advisory capacity to the Board of Trustees, has become greatly enlarged. Many angles of the provision of medical service for selected groups are now being discussed in order to determine the most practical ways and means consistent with the principles and policies set by the House of Delegates and the Board of Trustees.

Some of the activities recommended by Advisory Committees have been absorbed by government *for the duration*. The need for certain Advisory Committees has declined to a point where the personnel of these Committees can be used to greater advantage elsewhere. Advisory Committees necessarily vary in number from year to year. These Advisory Committees are appointed when, as, and if needed. The total number of members of The Medical Society of New Jersey available to participate in the work of the Society during the war will be limited. The burden of responsibility and effort placed on these men will be greatly increased. This fact is recognized and the activities of the Society will no doubt be curtailed, wherever this is possible without unduly jeopardizing the interests of the profession in New Jersey, or the public interests in which the profession serves.

Practical examples of the more recent efforts of the Advisory Committees may be listed as follows:

### ADVISORY COMMITTEES TO MEDICAL PRACTICE COMMITTEE

The Subcommittee on Medical Practice has considered and endorsed the activities listed below, which came within its jurisdiction:

1. The Fourth Edition of the New Jersey Formulary has been prepared and issued in coöperation with the Pharmaceutical Association.

2. The study of dispensary services in hospitals is being continued, but has been handicapped by the outbreak of war which limited the personnel available for this purpose.

3. A Joint Committee of Hospital Executives and members of the Auxiliary Medical Services Committee has entered upon a study of problems of mutual concern with the pur-

pose of suggesting ways and means to provide an agreeable and effective solution of these problems.

4. The Nursing and Nursing Education Committee has aided the nurses in preserving qualification standards during the emergency, especially as to standards of education and conduct of nursing service in hospitals rendered under the provisions made for supplementary nursing care in the civil defense program.

5. The important subject of industrial health has had especial attention by the capable Committee on Industrial Health and Hygiene. The health of the worker must receive the proper emphasis in industry needed to insure the greatest return to the worker himself and to the employer, and will be reflected in the quality of the product itself.

6. The important subject of Medical Care for the Indigent continues to be one of the most pressing problems and needs further study and experimentation. Several proposals are now under investigation with the idea of working toward a practical solution, employing ways and means acceptable and approved by the medical profession, the indigent patient, and the tax-paying public.

### ADVISORY COMMITTEES TO PUBLIC HEALTH COMMITTEE

Resolutions have been presented, through the Public Health Committee, offering to local, state and federal authorities the fullest coöperation of the medical profession in New Jersey, and urging the selection of the best qualified personnel, with adequate reward to interest and retain them. A study of the rejection of draftees was begun, and by recent legislation the Federal Government will assist in paying the cost of rehabilitation of rejectees who can be made fit for service in the armed forces. There are, however, many of the rejectees that can be rehabilitated for civilian work, the income from which will enable them to pay for the services received.

The subject of nutrition has come up for widespread attention, but the really effective work is being carried on by the doctors as heretofore with better understanding and more concrete evidence of accomplishment.

The Committee has endorsed the activities listed below, which represent the more recent efforts of its Advisory Committees:

1. The x-ray examination of all draftees,



and subsequent study by tuberculosis specialists has been of great assistance to the Selective Service organization in New Jersey. This was made possible through the efforts of the Advisory Committee on Tuberculosis Control.

2. The Cancer Control and Venereal Disease Control Committees have studied and endorsed the procedure and standards in use in New Jersey, and the recommendations of these Committees have been incorporated into the state and community programs.

#### COMMITTEE ON LEGISLATION

The Subcommittee on Legislation, throughout an unusually long and trying session of the Legislature, has faithfully followed through on proposed legislation and carried to members of both Houses, directly and through the County Key-men, the proper interpretation of the medical profession's attitude pro and con on the bills having important health implications.

The subject of qualification of applicants, who are graduates of foreign schools, for licensure by the State Board has been discussed and has been brought to the attention of the Welfare Committee members and the members of the State Board of Medical Examiners who attend our sessions.

#### COMMITTEE ON PUBLIC RELATIONS

The Public Relations Committee's work has been carried on through public addresses, exhibits, newspaper publicity and printed material, distributed upon request to members of the Society interested in specific aspects of medical service distribution. The responsibility for public relations is a heavy one and with the call to service of the Executive Secretary of the Committee an extra burden has been thrown upon the Chairman of this Committee, who has, with the assistance of the Executive Office Staff, faithfully met all demands made upon him by the Society.

#### RECOMMENDATIONS

1. Since war preparedness activities have been intensified, and government and industry have greatly aided the private practitioner of medicine in providing periodic physical examinations the need for the Adult Health Supervision Committee's efforts to promote check-ups and supervision has declined to an extent that it seems advisable that the Committee's competent personnel be directed in channels where the need at this time is greater, and that some Committees be dispensed with until renewed evidence of need is again apparent.

It is very helpful to have the Advisory Committees and Subcommittee, in their respective reports, clearly distinguish at all times between recommendations previously made and new ones. In reviewing the reports the repetition of recommendations is notable.

#### PUBLIC HEALTH RECOMMENDATIONS

1. *Standards for Infant Resuscitation*, be published in *The Journal* and commended to the attention of the Society members and the hospital authorities.

2. *Compensation for the Orthopaedic Surgeon in the care of indigent crippled children*; that the men in this State now doing this work be classified into three groups, depending upon their experience, training and clinics they run, and that each member of each group be compensated on a flat yearly basis.

#### MEDICAL PRACTICE RECOMMENDATIONS

1. The institution of *refresher courses*, to be operated at the close of the war, to further the training of medical officers discharged from the services.

2. Reduction of hospital out-patient load by 75 per cent—Committee on Hospital Relationships, Committee on Medical Preparedness with the Hospital Association to further study the matter and report to the House of Delegates which is urged to appoint a committee to work jointly with the Hospital Association to prepare recommendations to be sent to the County Societies and to the individual hospitals.

#### PUBLIC RELATIONS RECOMMENDATIONS

1. During the coming year all officers of the Society be encouraged to submit their talks in advance to the Committee; the Committee serving as a mechanism for distributing the talks through the proper channels to the public.

2. The program be confined to assistance in the war effort.

3. The Press Association and New Jersey Clipping Bureau services be continued.

4. The library of scripts be expanded by contributions suitable for lay audiences made by physicians who have addressed these audiences on health subjects.

The Chairman of your Welfare Committee wishes to thank the members for their faithful attendance at meetings. The Chairman also thanks the many others who have manifested their interest in the work of the Committee, through their attendance at our sessions, and by their ready response to all requests made upon them for assistance in the Committee's work.

# ANNUAL REPORTS TO THE WELFARE COMMITTEE

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## LEGISLATION

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B. S. POLLAK, M.D., Chairman, Jersey City

Stated simply, the principal function of the Subcommittee on Legislation is to advocate and support legislation which is in the interest of public health and to oppose legislation inimical to public health.

In our opinion, the method of handling legislation instituted by Dr. Wells P. Eagleton, father of our Welfare Committee, and its first Chairman, was basically sound and correct. The creation, a few years ago, of the Committee on Legislation as one of the four distinct subcommittees of the Welfare Committee, the fact that this Committee centers all its attention solely on legislative matters and the fortunate circumstance that there has been little change in the personnel of the Committee for several years have been productive, we think, of improvement in the technique of handling legislation. We are not, as yet, entirely satisfied with our efforts and our aim shall be to make further progress.

We have sought by every means compatible with the dignity of our profession and the standing of our Society to promote better understanding and good-will on the part of the legislators.

Conferences with the Legislators, attended by County Society Officers, Keymen, and the Executive Secretary of this Committee, have been held at least once, and in some instances two or three times, in over one-half of the counties of the State in the past two and a half years. That these conferences have resulted in a better understanding of our legislative objectives and improved relationships with the Legislators is attested by the County Society Officers, Keymen and Legislators alike. They have also made for better integration and implementing of the work of the Executive Secretary of the Committee and the County Legislative Keymen. Every year there is a change in the personnel of the Legislature of approximately one-third of the membership. In counties where such changes occur or where representatives will occupy key positions in the Legislature, such as Speaker or Majority

Leader, the desirability of a repetition of small group meetings with these Legislators is apparent.

The Committee wishes again to express its appreciation to the County Society Legislative Keymen for their excellent support and co-operation. In this connection it should be noted that some of the keymen and County Society Officers are meticulous in making prompt acknowledgment to the Legislators for their support of our point of view on public health legislation. We would urge that this practice be followed by all County Societies. Our experience convinces us that the Legislators are peculiarly responsive to these courtesies.

It will be impossible to give a report of any meaning at this time of pending bills in the State Legislature of interest to the Society. None of these bills as yet has gotten beyond the committee stage. The Legislature is now in recess until March 9th; presumably we will find on that date that a number of public health measures have been dropped into the Bill boxes in the interim. It is hoped that the Legislature will have advanced its work sufficiently to enable the Committee, in its supplemental report to the House of Delegates, to summarize the disposition of bills of particular interest to the Society.

The Committee desires to express its deep appreciation to Dr. Frederic J. Quigley for his devotion to the manifold duties assigned to him. We believe that the contact that Dr. Quigley has made with the respective Legislators has caused a better understanding with the Legislators regarding our objectives. During the past year, because of this existing understanding, the Legislative Executive Secretary has been frequently consulted concerning matters of legislation which were pending. It is obvious that such an attitude of cooperation redounds alike to the interests of the profession as well as to the public.

It is a pleasure to again record our appreciation of the fine coöperation of the Executive Offices.

## PUBLIC RELATIONS

CHARLES M. ROBBINS, M.D., Chairman, Newark

The work of the Public Relations Committee falls into two broad categories:

1. Routine assignments which carry on more or less consistently throughout the year.
2. Special projects which, for a short time, require the concentrated efforts of the Committee staff.

The bulk of the routine work consists of supplying scripts to speakers and supplying speakers for lay organizations. Also included is the preparation and distribution of newspaper releases and clipping classifications, and the mounting of newspaper clippings. This work is made possible through the machinery of the Press Association on the one hand and the New Jersey Press Clipping Bureau on the other. These routine jobs have been carried on all year at a fairly steady pace. They have resulted in a uniform pouring out of publicity favorable to Organized Medicine in this state. It is impossible to determine how many individuals have thus been reached, but considering the hundreds of newspaper articles published and the thousands of persons who must have heard the many talks given during the year, it seems reasonable to conclude that a large portion of the New Jersey population has been reminded of the existence of Organized Medicine one way or another during the last few years.

Special projects included a large-scale speaking program for the Kiwanis Clubs in New Jersey, the organization of publicity for the Fall Clinical Conference, and the implementation of the Society's medical defense program.

The Kiwanis Club undertaking is probably unique in the history of Organized Medicine. We secured speakers for 85 Kiwanis Clubs during October, and the Committee's staff wrote the scripts and handled very extensive newspaper publicity. The provision of speakers for 85 clubs during one month, and the planning of the time and place of the meetings, the distribution of scripts, the training of speakers, the preparation of publicity—all this required concentrated effort on the part of the Committee staff. Results were extremely gratifying and well worth the effort. Inquiries as to the mechanism of the program have been received from other state medical societies and from other medical periodicals.

The Fall Clinical Conference was an opportunity for the Public Relations Committee.

We secured in advance the addresses to be delivered to the members. We rewrote them in a form acceptable for newspaper release, and we provided the newspapers with specially prepared material during the Conference itself. The Public Relations Committee also took over the function of keeping the medical profession itself aware of the Conference by means of letters read at the meetings of County Societies, notices inserted in County Society Bulletins, placards placed on bulletin boards, and feature articles in our Journal. Since the Fourth Annual Fall Clinical Conference was the best attended mid-year meeting in our history, it is apparent that the program was carried to a successful conclusion.

The place of the Public Relations Committee in the war effort is less well defined. The Committee is prepared to let the public know of the tremendous contributions which Organized Medicine has made to national defense; especially the rôle of the medical societies in the procurement of medical personnel for the Army and Navy, and in the consummation of the health aspects of the Civilian Defense program. How far the Committee should go in publicizing the position of Organized Medicine yet remains to be determined.

The Committee has provided a special editorial every month in *The Journal* of our Society, and has kept the members well informed of its activities through special articles.

This report would be incomplete without an expression of thanks to the many persons who have taken part in the program. The County Medical Societies were especially helpful in the operation of the Kiwanis project. The Woman's Auxiliary was most valuable in reaching non-medical organizations. The Editor of *The Journal* was generous in the allotment of space to public relations material. The Executive Office was indispensable in doing the enormous amount of mimeographing, mailing and clerical work necessary. Dr. Scott placed at our disposal a great deal of newsworthy material about the Medical Service Administration and the Medical Preparedness Committee. Dr. Quigley kept in close touch with us, and all legislative questions having a Public Relations facet were referred to us. The work of the Public Relations Committee was smoothly geared into the projects of the other committees through the coordination supplied by Dr. Wilkes, Executive Officer.



## MEDICAL PRACTICE

R. L. SHARP, M.D., Chairman, Camden

The Medical Practice Committee started the past year with certain objectives:

First: The completion of the Hospital Survey together with the establishment of post-graduate training in clinics.

Second: A permanent plan for care of the indigent similar to the old ERA Plan.

Third: Changes in the Workmen's Compensation law, especially the completion of the hernia clause.

Fourth: The completion and distribution of the new edition of the New Jersey Formulary.

Fifth: Further educational work at hospitals toward establishment of the medical auxiliary services in their proper positions; i.e., under the direction of a physician.

Sixth: The establishment of a definite program on Industrial Health and Hygiene.

Early in the fall, our President, Dr. Thomas K. Lewis, asked that we bend all efforts toward preparedness, omitting those activities which were not essential at the time. Hence, some of the objectives have not been achieved but we have continued to keep them abreast so that the work already accomplished shall not have been in vain.

Perhaps with the changes which will occur it is well that we have not pushed some measures, for our idea of what is essential now may be entirely different when the present emergency is over. Perusal of the reports of the Advisory Committees will show that they have been active and have performed well the tasks imposed.

The Medical Practice Committee is grateful to them and through their Chairmen expresses our appreciation.

## PUBLIC HEALTH

STANLEY NICHOLS, M.D., Chairman, Long Branch

The entry of the United States of America into the world-wide war for human liberty, on December 7th, 1941, made it essential for our Public Health Committee to immediately examine the various factors and our increased responsibilities involved in the protection of health of the citizens of New Jersey in which the medical profession of New Jersey must assume its full share during this national crisis. This our committee has done, with the help of our twelve Advisory Committees, each of which has been instructed to examine its stated objectives with one question in mind—namely, "Will the accomplishment of this objective make an essential contribution toward winning the war?" Where the answer is "No", priority should be given to those activities of our committees which will contribute most directly to the maintenance of health essential to both the military and civilian population of New Jersey.

The responsibilities of our Public Health Committee, and its Advisory Committees, have been at least doubled by the current wartime needs, and we are taking steps to make our activities, through the participation of the members of the State and County Medical Societies, efficient and economical as a contribution

toward winning the war. If victory is to be achieved and the private practice of medicine continued, we must prove that private physicians, in their State and County Societies, can carry on effectively to meet the Public Health and medical service needs of our people. To achieve this goal, our committees must lay aside non-essentials. This we will do at once.

This report will be short, as the Advisory Committees will render their own reports. The recommendations of the Public Health Committee as approved by the Welfare Committee are included in the annual report of the Welfare Committee.

We wish to thank the Chairmen and the members of our Advisory Committees for their faithful service during the year. Our appreciation is also expressed to the official representatives of the State Departments of Health, Public Instruction, Institutions and Agencies, and to the representatives of the Dental, Nursing, Pharmaceutical, and Health Officers' groups, and the New Jersey State Medical Association who met regularly with us and helped us in the solution of Public Health problems as they arose. We welcomed two new Committee members—Dr. Wilson G. Guthrie, Director of Health and Physical Education of

the State Department of Public Instruction, and Dr. Harvey M. Ewing, Chairman of the newly appointed Advisory Committee on the Prevention and Control of Heart Disease, a much needed committee which was added during the year.

The major objective of our Public Health Committee since its inception in 1931, has been that the practicing physician should, wherever possible, assume increasing responsibility in all phases of Public Health endeavor. We have sought to enlist an increasing participation by the private practitioner in Public Health activities in New Jersey. In this effort we have received encouraging support of the members of The Medical Society of New Jersey. Cordial

and effective working relationships have been established with the other allied professions and with Health and Welfare Agencies, both public and private in the State. We willingly coöperate with allied professions and approved agencies, both military and civil. This war challenges us all to make sacrifices and our acceptance of extended responsibilities during the next few years must be faithfully discharged if we are to meet the challenge. It is our belief that the health and welfare professions and agencies in New Jersey will continue united and coördinated and by joint effort will help in the development and maintenance of the high degree of Physical Fitness, Morale and Faith in our democratic ideals among New Jersey citizens essential to victory.

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## ANNUAL REPORTS TO THE SUBCOMMITTEE ON PUBLIC HEALTH

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### ADULT HEALTH SUPERVISION

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WILLIAM H. VARNEY, M.D., Chairman, Washington

The Adult Health Supervision Committee has limited the scope of its activities this year to a consideration of the causes of rejection of men from military service, and a study of what measures had best be taken to rehabilitate these rejected men. A survey showed that a high percentage of these men could be rehabilitated for military service, and that a larger number could be rehabilitated to make them more useful in civilian defense work. As a result of this study, the following resolution was recommended to the Board of Trustees, and was adopted by that Board with the proviso that it embody the free choice of physicians.

*"Be It Resolved,* That The Medical Society of New Jersey, through its component County

Societies, endorse the rehabilitation program of the Federal Government by urging rejectees who cannot be made fit for military service to seek proper medical care either from private physicians or through clinics to make them better fitted for the strenuous duties of civilian defense work. It is urged that each Society provide a social service follow-up on these cases."

As in the case with the other committees of this Society, the emphasis was placed on activities which would contribute to our war effort, and it was thought advisable to temporarily abandon several other projects, and to concentrate our efforts on the above recommendation. The passage of this resolution by the Board of Trustees was indeed very gratifying to us.

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### CANCER CONTROL

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OTTO R. HOLTERS, M.D., Acting Chairman, Asbury Park

The Advisory Committee on Cancer Control has set as its immediate objective in the 1941-42 session the preparation of a cancer bill and its presentation for legislative enactment. This

has been accomplished with the coöperation of the State Department of Health.

The tentative cancer bill is now in the hands of Senator Summerill and is expected to be

introduced in the Legislature on March 9th, 1942.

The Committee has had four meetings during the current session; these were devoted to the discussion of the tentative cancer legislation, the planning of an effective educational program in the interests of cancer control, and the stimulation of cancer control committees of County Medical Societies.

The Committee suffered a great loss in the untimely passing of its Chairman, Dr. Edgar A. Ill, whose sustained interest in cancer control added much enthusiasm to the work of this Committee.

There are no specific recommendations to be brought to the attention of the Public Health Committee.

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## CHILD HEALTH

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CHESTER R. BROWN, M.D., Chairman, Arlington

The goal set for the year was the safety and the improvement of the health of the infants and children of New Jersey, with special attention to those things that pertain to the present national emergency.

There were two meetings of the committee as a whole on January 7 and February 18, 1942. Members were consulted on important matters by mail.

The topics discussed and the results achieved are as follows:

*Evacuation Plans.* Evacuation plans for New Jersey children were accepted and submitted to the State Society for endorsement. A letter was sent to the chief pediatrician of each hospital in the state, requesting him to be sure that in the emergency plans of his hospital, protection is provided for infants and children, with special reference to the importance of identifying infants with footprints, etc.

*Immunization.* More complete immunization to diphtheria, smallpox and whooping cough, with particular reference to the participation of the public schools was discussed. A definite plan for immunization against diphtheria was recommended, and a letter was sent to the State Department of Public Instruction requesting them to influence the several boards of education in New Jersey in making vaccination and immunization against diphtheria compulsory. A letter was also sent to the State Board of Health on immunization. A member of the committee was instructed to present the best plan for immunization against whooping cough at the next meeting of the committee.

*Premature Ambulance.* Steps have been taken to procure a premature ambulance for the East Orange General Hospital as an experiment.

*Resuscitation of the Newborn.* The Committee adopted the recommendations for new-

born which were accepted by the Maternal and Child Welfare Committees of the Essex County Medical Society, and decided to present them to the State Society for adoption.

*American Medical Association Meeting.* A letter was sent to the Chairman of the Pediatric Section of the American Medical Association, extending this committee's services during the coming meeting of the American Medical Association in Atlantic City.

*Data on the Newborn.* Methods for collecting data on the newborn from the maternal record books which are kept by most of the New Jersey hospitals was referred to the Chairman and to the Director of the Bureau of Maternal and Child Health of the State Department of Health.

*Presentation of Pediatric Subjects at County Society Meetings.* Each County Society was requested to include in its program at least one meeting a year at which pediatric subjects could be discussed. Nine county societies have reported that they have had one meeting devoted to a pediatric subject.

*Publication of Pediatric Articles.* The Chairman was instructed by the Committee to make arrangements with the Publication Committee for the publication of an article on pediatrics in each issue of *The Journal*.

*Information on Still-births.* The advisability of requiring more complete information on still-births on the hospital records and the official reports was discussed. It was decided that this was a province of the Maternal Welfare Committee and not the Child Health Committee.

*Post-Graduate Courses for Nurses in the Care of Prematures.* The proposed course at the New York Hospital and the possibilities of establishing such courses in New Jersey were discussed and referred to a member of the Committee for further study.



## CONSERVATION OF VISION

ELBERT S. SHERMAN, M.D., Chairman, Newark

The activities of this Committee during the year have included:

1. Coöperation with the New Jersey Commission for the Blind.
2. A study of visual defects as a cause of Army rejections.
3. A study of the methods employed in the examination of school children's eyes.
4. The study of a program offered by the New Jersey Optometric Association to the Defense Council, offering aid in connection with defense activities.

Work on the last three items is incomplete.

In last year's report reference was made to our endorsement of a plan elaborated by the Federal Social Security Agency of the Social Security Board for a statistical study of blindness among applicants for aid to the blind in various States including New Jersey. Since then the New Jersey Commission for the Blind has appointed a supervising ophthalmologist who, with the coöperation of the Division of Statistics and Research of the Department of Institutions and Agencies, has made a complete statistical study of the causes of blindness of the 772 recipients of aid to the blind in New Jersey. The report is too long to be

summarized here, but is available to anyone interested. During the year our Committee has recommended six names for addition to the list of approved ophthalmologists of the Commission for the Blind for examining applicants for aid to the blind.

Of the men called under the Selective Service Act about fifteen in each thousand are rejected. One of the principal causes of rejection is defective eyes. This cause accounts for 11 to 13 per cent of the rejections. The ocular findings reveal that about 70 per cent of these are due to myopia and compound myopic astigmatism and 16 per cent to amblyopia. Conditions of this kind can often be helped materially or prevented if discovered in early childhood, and emphasize the importance of pre-school examinations of eyes.

Allegations have come from various sources that the eyes of school children in this State are being seriously neglected. We find that these claims are exaggerated. Our Committee hopes to investigate the need for increased facilities for the examination and treatment of eyes in rural districts, and if the need is apparent, may recommend the formation of a part-time traveling clinic with a paid ophthalmologist.

## CRIPPLED CHILDREN

ELMER P. WEIGEL, M.D., Chairman, Plainfield

### COMPENSATION FOR THE CARE OF CRIPPLED CHILDREN

The Committee has discussed at length the question of compensation for the Orthopaedic Surgeon in the care of indigent crippled children. It is the opinion of this Committee that, inasmuch as the Federal Government makes certain funds available for the care of crippled children, and that they have up to date furnished everything except compensation for their professional care, we should receive such compensation in the future. This matter has been discussed with the representatives of the Crippled Children's Commission, and also with the Children's Bureau from the Department of Labor in Washington, and it was their advice that we make recommendations as to how this compensation should be made.

Our Committee therefore recommends that the men in this State now doing this work be classified into three groups, depending upon their experience, training and clinics they run, and that each member of each group be compensated on a flat yearly basis.

The Committee realizes that in the past the profession has been of the opinion that we only accept such compensation upon a fee basis. We feel that this is now impractical for two reasons: first, because there is not enough money available to pay the surgeon on a fee basis; and secondly, because it is the opinion of the Committee that compensation of that type might stimulate unwarranted operative procedure. It is also the opinion of the Committee that arrangements might be made with

the Crippled Children's Commission to obtain \$25,000.00 from the Federal Government for this purpose.

#### CARE OF CEREBRAL BIRTH PALSY

The Committee has also considered at great length the question of Federal and other monies that are being expended in an effort to

treat cerebral birth palsy, and while we definitely feel that some things have been accomplished in this regard, we are of the opinion that the results do not justify the expense inasmuch as only the cases with the very highest mentality have been treated, and the results in these cases have been such that they did not diminish their indigency.

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## MATERNAL WELFARE

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ARTHUR W. BINGHAM, M.D., East Orange

The Advisory Committee on Maternal Welfare is following the twelve-point program as described in the *Journal* of December, 1936, page 716. The program, as carried out all over the State, includes most of the features of maternal welfare.

#### THE COMMUNITY HOSPITAL

The hospitals taking obstetrical cases are showing more interest in maternal welfare and are coöperating well. New rules of procedure and a list of "Obstetrical Don't's" have been sent to all the hospitals. If any hospital has been omitted, please notify the chairman.

#### OBSTETRICAL CONFERENCES

These are being held in most of the counties and are of educational value. Maternal deaths and difficult cases are discussed. All physicians interested in obstetrics are invited to attend.

#### LECTURES

While no regular lecture courses have been given, the majority of the counties have had at least one meeting devoted to obstetrics.

#### REFRESHER COURSES

Refresher courses are given without charge to any physician in the State who wishes to spend a few days or longer at Margaret Hague Maternity Hospital in Jersey City. A letter of recommendation from the Chairman of the Committee on Maternal Welfare is all that is necessary.

#### FIELD PHYSICIANS

The Field Physicians have been very helpful in working with the State Committee. Their duties have been stated in previous reports.

#### MATERNAL DEATHS

All reports on deaths connected with pregnancy are now sent to the Field Physicians for investigation. They are then sent to the chairman for study and classification. By this method our statistics are as accurate as can be obtained.

#### OBSTETRICAL REPORTS OF HOSPITALS

Over one hundred annual obstetrical reports of hospitals are received. They are not simply filed away but they are studied as to the number of deliveries, Cesarean sections, toxemias, hemorrhage, stillbirths, and deaths, etc., and the findings tabulated. The maternal deaths reported are compared with the histories on hand and frequently the two do not agree. This is often due to the death certificate being carelessly filled out by an intern who does not always give the true cause of death. If every attending physician would check the death certificate before it goes out it would save a great deal of correspondence. Most of the hospitals are using the new obstetrical record book that was described in the *Journal* of June, 1940, page 325. It is a great aid in making out the annual report as well as in keeping accurate records. The second edition has been printed with a few changes and is now on sale.

#### NURSING DELIVERY SERVICE AND CONSULTATION SERVICE

A physician having a home delivery in the low-wage group may call any graduate nurse and she will be paid by the State Department of Health through the Bureau of Maternal and Child Health. Also, a physician needing consultation may call any competent physician and the consultant will be paid in the same

way. These services are available only for home deliveries of patients in the low-wage and indigent groups. Except in an emergency one of the listed consultants should be called. The field physician has the list.

#### SYSTEMS OF PRENATAL CARE

The importance of prenatal care is constantly stressed. Two systems are offered for the low-wage and indigent groups of patients:

A. The maternity center system, in which there are prenatal centers and visiting nurses working together; and

B. The community system, in which the visiting nurses report cases to the field physician; and he assigns the patients to physicians in the neighborhood for prenatal care. Both systems are in use, but more should be organized.

#### MATERNAL DEATHS

This year statistical studies were published in seven different articles giving in detail the deaths occurring due to the different causes. This was done in order to give the physicians more details regarding complications causing maternal deaths. The reprints will be published in one volume. If any physician or hospital

would like to have a copy, please notify the chairman.

#### MATERNAL WELFARE ARTICLE

A maternal welfare article is published in the *State Medical Journal* each month, except the month when the program for the Annual Meeting is published, when there is not sufficient space. This has been carried on for over six years.

#### A LESSON FROM A DEATH CERTIFICATE

A very brief paragraph with this title is published eleven months of the year in the *State Medical Journal*. They are widely read.

Tentative plans have been made to care for obstetrical patients in cases of disaster, air raids, or black-outs.

The chairman has visited several counties to discuss some of the obstetrical problems and has found great interest shown everywhere. While the tentative maternal mortality rate for 1941 of 2.6 per 1,000 live births is good, it should be lower; for, a careful study of the deaths shows that many might have been prevented.

We greatly appreciate the fine coöperation of the various agencies of the State which have helped so much in this work.

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## MENTAL HYGIENE

JOSEPH E. RAYCROFT, M.D., Chairman, Princeton

The Chairman of the Mental Hygiene Committee has been fully occupied with other duties in connection with National Defense and has been unable to call together the Committee as a whole, but he has kept in touch with the members. The members of the Committee have contributed to the program outlined, through their own efforts to promote the objectives announced. Drs. Trippe and Gordon have prepared and delivered papers

and by personal contacts have promoted these objectives.

The national government has contributed toward these objectives in their examination of draftees, and in their subsequent supervision and placement of cases discovered have furthered the aims of our Committee. Undoubtedly the individual members of the Committee have contributed valuable services as opportunity was presented.

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## PNEUMONIA CONTROL

THOMAS M. KAIN, M.D., Chairman, Camden

The Committee has held no meetings this year, and therefore has no report to make at this time.



## PREVENTION AND CONTROL OF HEART DISEASE

HARVEY M. EWING, M.D., Chairman, Montclair

This Committee held its first meeting on December 17, 1941. Dr. Jerome Kaufman was appointed Secretary. After a thorough discussion, the Committee decided upon the following three-point program:

1. That the Committee would offer its services as an Advisory Committee to the Governor of the State of New Jersey or such person or agencies as he might designate. The Committee would propose to function in an advisory capacity regarding the rehabilitation of men rejected by the State Selective Service Board because of heart disease or in other matters pertaining to the subject of heart disease in its relation to the present emergency. In this connection it was proposed to contact all of the existing heart clinics in the State with the idea of using the heads of such clinics as keymen in an elaboration of a more detailed program to be developed after conference with State authorities.

A letter sent to Governor Edison last December advised him of the above plan. He referred this matter to Colonel E. N. Bloomer, Acting State Director for Selective Service, who stated that while he had no definite direction from National Headquarters of Selective Service regarding rehabilitation he was "Cognizant and keenly appreciative of the splendid coöperation of the members of The Medical Society of New Jersey", and "would certainly avail himself of the assistance of your Committee upon the institution of the rehabilitation program". Dr. J. Lynn Mahaffey, State Director of Health of New Jersey, met with the Chairman of the Committee at the suggestion of the Governor.

Contact has been made with 56 hospitals asking whether they operate a cardiac clinic, who is in charge of the clinic, and whether they would be willing to take part in our program.

To date, 42 returns have been received; 40 stating their willingness to coöperate.

2. The second point in our projected program is the study of a plan submitted to the Crippled Children's Division of the United States Children's Bureau and to secure approval of this plan, and funds for the commencement of a New Jersey Program.

3. A study of the heart disease problem in the State of New Jersey to be followed by concrete recommendations looking toward prevention and control of heart disease.

It was thought that the execution of these last two items might have to be deferred until after the war, but at a second meeting on February 18, 1942, it was decided to attempt to initiate a program which could be carried on for the present without the expenditure of funds. According to this plan an attempt would be made through the agency of the various members of the State Heart Committee to have a local heart committee appointed in each county. Such committees would then be able to study heart disease in their own locality and to disseminate information, working through existing agencies such as the public school services, heart clinics and social organizations. Such committees already exist in at least three counties. The State Advisory Committee would propose to function as a central coördinating agency and bureau for the accumulation of such data as might be gathered by the county committees. Members of the State Advisory Committee would be available as consultants to the local committees or as speakers at meetings which the local committees might arrange. Such an organization would also be able to function in developing a program for educational and occupational advice and training of children with heart disease, again working through such agencies as might already be available in each county.

## TRAFFIC ACCIDENTS

MILLARD F. SEWALL, M.D., Chairman, Bridgeton

The efforts of the Traffic Accidents Committee for this year have been devoted to the collection of statistics covering all pathological conditions which are, or may become, hazards on the highway. To this end we have asked our membership in the State Society to submit data on the questionnaire inserted in the

February *Journal* of The Medical Society of New Jersey, page 108. We hope for full coöperation in this matter. This seems to be the only method of acquiring these statistics.

The Commissioner of the State Motor Vehicle Department has asked for data on which to base the need for regulatory legislation affecting this class of drivers.

## TUBERCULOSIS

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ABRAHAM E. JAFFIN, M.D., Chairman, Jersey City

As in previous years, the Committee has attempted to confine its activities to a few major problems and to concentrate upon their solution.

Early last fall, in coöperation with the New Jersey Tuberculosis League, a special joint committee undertook a revision and clarification of the diagnostic classification for use in the reports from tuberculosis clinics and school surveys. After these were approved by the Advisory Committee, they were distributed through the New Jersey State Tuberculosis League to all tuberculosis clinics and to the Department of Public Instruction. The adoption of these forms by all the school districts in the state should clarify and simplify the reports so that a clearer analysis of the findings will be secured.

In May, 1941, the Committee ended a seven-month period of operation of the x-ray examinations for the army at the various New Jersey induction stations in coöperation with the Medical Defense Committee.

The Committee was again called upon last February to provide equipment for the Camden station.

In coöperation with the Department of Health, an effort is being made to improve the reporting of cases of tuberculosis. It has long been a question with some of us as to whether or not *all types* of tuberculosis should be reported. This question has arisen because of the increasing percentage of cases of healed primary infections as well as minimal reinfection lesions being found amongst apparently well people through the wider use of x-ray surveys. These cases are obviously non-communicable forms of tuberculosis. The value of reporting such cases is purely statistical. To avoid labeling these individuals with tuberculosis and the possibility of embarrassing them with respect to life insurance or employment, it may be desirable or even necessary to estab-

lish two classifications by the Boards of Health, one to cover communicable forms of tuberculosis and another for non-communicable types.

The Advisory Committee is enjoying the coöperation of the State Board of Health and the Tuberculosis League in the consideration of this and several other questions involving the responsibility of the medical profession in the tuberculosis problem.

At the request of the American Trudeau Society the Committee has made a survey of the post-graduate facilities for tuberculosis in New Jersey through members of the Committee as far as their knowledge of the subject permitted. In view of the diversity of residence of the various members of this committee, the probabilities are that a fairly good estimate has been made.

It appears from reviewing the replies that in some counties the medical societies have provided refresher courses in the subject while others have held an annual symposium at one of their meetings. In connection with the post-graduate courses in some of the counties the state and county tuberculosis leagues have rendered valuable aid. In several counties the private practitioner is making increasing use of the tuberculosis clinics for consultation purposes. A further extension and better organization of post-graduate courses in tuberculosis would, however, be very desirable.

It is apparent that the collective effort of the Committee for several years has resulted in an increased appreciation by the physicians as well as the public of the value of high school and college surveys, induction x-ray examinations and case finding by x-ray in all apparently well people.

The Chairman wishes here to express his appreciation again for the whole-hearted coöperation of all the members of the committee and for the invaluable aid of the executive office in the preparation and conduct of the meetings.

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## VENEREAL DISEASE CONTROL

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C. BYRON BLAISDELL, M.D., Chairman, Long Branch

Annual reports since 1936 have shown the rapid expansion of venereal disease control measures both legislative and clinical.

It is reassuring to know that this program has resulted in giving New Jersey a most

favorable position in this field of public health and medical endeavor. Reporting that such subjects as (1) Clinic Extension, (2) Free Distribution of Drugs, (3) Appointments of Doctors for Clinics have proceeded adequately

to meet the civilian situation, emphasis is this year placed on the expansion of activities occasioned by the National Emergency.

*Syphilis:* In 1936 approximately 54,000 Wassermann tests were done in New Jersey in contrast with over 250,000 in 1941. A remarkably low number of chancres have been reported from the Army Centers in our State, indicating successful prophylaxis instruction as well as control of promiscuity and prostitution. The difference in the vigor of the attack on syphilis in 1940 and 1941 may be estimated by recalling that in our last year's report, it was stated that through several months of induction, 1,000 draftees had been found to be infected; this year at one registration alone 45,000 Wassermann tests were made and 2,000 positives discovered, all this in three days. Five hundred and forty-six doctors participated in this ambitious program established by the Bureau of Venereal Disease Control and planned by Dr. Daniel Bergsma. These doctors, most of them members of our Society, the nurses who volunteered to assist them and the local boards of health should all be congratulated in having carried out this unselfish and arduous piece of work. Private physicians and clinics stand ready to absorb this new load.

*Prostitution:* Through frequent conferences

with the State Department of Health, State Police, Army Medical Corps representatives, Health Officers, etc., we have discussed, criticized and helped devise measures for the control and elimination of this menace around troop concentration and defense industry areas. The results are excellent.

*Gonorrhea:* No organized plan of control has been added during the past year except in local clinics or at the direction of individual boards of health. The successful results from sulfathiazole, plus the education of the public, and available prophylaxis have all conspired to combat this disease more successfully.

*Summary:* The expansion of the work of the State Department's Bureau of Venereal Disease Control has been so vigorous and far-reaching that we do as a committee offer our congratulations to the State Department of Health for its work in this field. Regarding the shortage of funds caused in part by reduced appropriations and by increasing costs occasioned by expansion of activities and by rise in price of materials, a resolution was introduced to the Welfare Committee and endorsed by it which recommended that \$50,000 be appropriated by the State Legislature to preserve the work in the venereal disease campaign and prevent serious curtailments. We have urged that this resolution be considered favorably.

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## ANNUAL REPORTS TO THE SUBCOMMITTEE ON MEDICAL PRACTICE

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### AUXILIARY MEDICAL SERVICES

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SIGURD W. JOHNSEN, M.D., Chairman, Passaic

The Committee on Auxiliary Medical Services wishes to make the following report of its activities for the year:

First. Inasmuch as no name that is sufficiently simple and yet all-embracing to include the four divisions represented by this Committee, namely Clinical Pathology, Roentgenology, Physiotherapy and Anesthesia, could be decided on, the Committee recommends that the old name be retained.

Second. A survey of portable x-ray facilities available in the state is being prepared, and also a study of a portable laboratory unit for civilian defense purposes.

Third. A Committee named by the New Jersey Hospital Association will hold a meeting with our Committee to explore the possibilities

of mutual coöperation in the field represented by this committee.

Fourth. Inasmuch as our State Society has now embarked on an insurance plan whereby anyone may purchase complete health insurance on an annual pre-payment basis, and as a result of the relationship with the Hospital Service Plan, roentgenologists, clinical pathologists, physiotherapists and anesthetists are practically excluded from the benefits of this insurance plan as proposed by the Medical Service Administration of New Jersey, it was deemed pertinent that this Committee again affirm that their endeavors are part of the practice of medicine, and that steps must be taken to safeguard these endeavors to meet with the recently stated resolution of both the American College of Surgeons, and the American Medical Association.



## CONTRACT PRACTICE

ANDREW C. RUOFF, M.D., Chairman, Union City

The Chairman of the Committee on Contract Practice attended all meetings that were called during the year.

Nothing that concerned this Committee has been referred to it during the year. It was our thought that we might best assist in the program of Medical Preparedness by collecting data on the available emergency services of both Casualty and Life Insurance Companies in the State. However, since the Committee

was conscious of the fact that this matter was under the direct supervision and control of Dr. Schlichter, it has awaited the call of Dr. Schlichter's Committee, and when such call is received, we shall proceed in whatever capacity we might be asked.

No matters in the nature of grievances presented themselves to this Committee, and hence there was no need for calling a separate meeting of the Committee.

## HOSPITAL RELATIONSHIPS

HENRY B. DECKER, M.D., Chairman, Camden

The Advisory Committee on Hospital Relationships planned to continue the survey of hospital out-patient departments during the past year. With the help of a federal grant a study of the out-patient department records of McKinley Hospital in Trenton was attempted. This was done under the supervision of Dr. Emil Frankel of the State Department of Institutions and Agencies. It was not entirely satisfactory in that it did not give the data in which we were chiefly interested.

It is now contemplated to ask each hospital in the State, maintaining an out-patient department, to complete a questionnaire on one hundred new patients. It is felt that this will give us sufficient data to complete the survey.

A secondary objective of this committee is

the organization of refresher courses for general practitioners in out-patient departments. This has been outlined in previous reports. The Committee Chairman contacted Dean Miller of Rutgers University during the past year. Since the seventh of December the plan has been submerged by the war activities. It is felt that it should be developed so that it may operate at the conclusion of the war and further the training of medical officers discharged from the services.

The entrance of physicians in the military services will shortly create a lack of personnel to operate out-patient departments. It is felt that each hospital should be advised to immediately take steps to reduce its out-patient department patient visit load by 75 per cent.

## INDUSTRIAL HEALTH AND HYGIENE

JAMES M. CARLISLE, M.D., Chairman, Westfield

Your Committee fully realizes that it has important responsibilities in executing an effective war program. We know that when disabled, participants in industrial production become liabilities at a time when optimal use of all national assets is an inescapable necessity for the preservation of our American way of life.

Your Committee wishes to acknowledge the very real and active coöperation and support given us by the Department of Health during the past year. Without the genuine assistance of Dr. J. Lynn Mahaffey and his assistants, it would not have been possible to achieve the

same measures of success that we have enjoyed during the past year. I should also like to take this occasion to acknowledge our indebtedness for the all-out support given us by the State Medical Society through its President and his appointed representatives, as well as the support and coöperation of the Medical Preparedness Committee.

The work of your Committee during the past year may be seen by the following list of activities in which the Committee participated:

Third Annual Conference of the N. J. Social Hygiene Association, New Brunswick, N. J.

National Nutrition Conference for Defense, Washington, D. C.

A. M. A. Convention and Industrial Hygiene Conference, Cleveland, Ohio

Symposium on Tuberculosis in Industry, Saranac Laboratory for the Study of Tuberculosis, Saranac Lake, N. Y.

Clinic on Health in Industry of National Association of Manufacturers, Newark, N. J.

Symposium on Industrial Health, The Industrial Council, Hackensack, N. J.

American Public Health Association, 70th Annual Meeting, Atlantic City, N. J.

New Jersey Self Insurers' Association, 9th Annual Meeting, Newark, N. J.

Fall Meeting of New Jersey Tuberculosis League, Inc., Newark, N. J.

Consumers' League of New Jersey, Newark, N. J.

Fourth Annual Congress on Industrial Health, sponsored by Council on Industrial Health, A. M. A., Chicago

Post-Graduate Course on Industrial Health and Hygiene at Columbia University, New York City.

State Nutrition Council, Trenton, N. J.

Symposium on Industrial Health, DuPont Company, Wilmington, Del.

Conference on "Conservation for Victory"  
Greater New York Safety Convention and Exposition.

The Committee worked in collaboration with the New Jersey Association of Industrial Physicians and arranged for a program of "Industrial Medicine" in eight of the outstanding industrial plants in the State.

Your special attention is directed to those parts of the program which apply to the Bureau of Industrial Health and Hygiene functioning on the basis of reciprocal coöperation among the Department of Health, the State Medical Society and the New Jersey Association of Industrial Physicians. The Chairman attended a meeting of the Medical Preparedness Committee in an effort to get representation on this Committee and solicit its aid in furthering the formation of a Bureau of Industrial Health and Hygiene in our State. He was later elected a member of the Medical Preparedness Committee and attended a conference in Trenton with representatives of the Department of Labor, Department of Health, State Medical Society and Washington representatives of the U. S. P. H. S. A resolution was presented to the Board of Trustees of the State Society asking their endorsement of the establishment of a Bureau of Industrial Health and Hygiene in New Jersey.

Aside from the specific activities of the personnel of your Committee, we have also collaborated in the industrial health services of the Bureau of Industrial Hygiene now functioning in the New Jersey State Department of Health. During the past five months studies have been made of fifty-six plants concerning their medical set-ups, the provisions for the prevention and control of illness regardless of cause. Forty-seven investigations were made to detect and study environmental health hazards in industrial establishments. In most of the above 103 contacts made in approximately 60 plants, detailed reports were prepared and recommendations made, if indicated. At least 36,000 workers were involved in the plants covered; most of the latter, incidentally, have national defense contracts. This work included a survey of all the fur-cutting and rough-felt body hatting factories in the State. On the basis of this survey, a report was made in which it was recommended that action be taken to prohibit the use of mercurial carrot and mercurially carroted fur in these industries. This project was recommended and requested by the Conference of State and Provincial Health Authorities of North America in line with similar activities throughout the country.

In addition to a certain amount of administrative work, consulting services pertaining to the plant worker, environmental, medical and nursing problems were supplied by mail, long-distance telephone and personal visits in the offices, hospitals and plants.

A great deal of effort has been devoted to the compilation of data and the preparation of instructions that should be of value to those physicians desiring information concerning increased activities in the field of industrial medicine.

A series of editorials have been prepared which we hope will appear in early consecutive issues of *The Journal* of the State Society.

During the past year your Committee has attended on a number of occasions conferences with the Department of Health in an effort to organize and obtain official recognition of the Bureau of Industrial Health and Hygiene. The wishes and interests of the State Society have been presented and protected not only at these meetings but at the three meetings with Governor Edison and with the Department of Labor.

The Bureau of Industrial Health and Hygiene is endeavoring to furnish a statewide service to local boards of health, physicians and nurses, all industries and all state agencies on questions of occupational diseases and hazards.

## THE MEDICAL CARE OF THE INDIGENT AND LOW-WAGE GROUP

HERSCHEL S. MURPHY, M.D., Chairman, Roselle

Our Committee felt that our program for the year could be divided into three parts:

1. To coöperate with the Medical Service Administration of New Jersey in inaugurating plans for the care of the indigent in New Jersey, based upon policies approved by this Committee. These policies would approve of the operation of indigent plans allowing for free choice of physician and a cost based upon the prevailing sick rates, to be operated on an insurance basis. By this method, after determining sick rates of the indigents in a community, it would be possible to estimate the cost to the municipality for the coming year, or a common period, thus assisting the communities in making due allowances in their budgets. This has appealed to the governing bodies of certain communities.

2. To coöperate with the Medical Service Administration in its efforts to provide medical care to persons of the low-wage group.

3. To coöperate with State authorities in carrying out the state plan for the medical and hospital care of the indigent as proposed by The Medical Society of New Jersey two years ago.

To make our efforts effective, the Committee approved of the inauguration of an indigent plan by the Medical Service Administration in larger municipalities of the state, feeling that from the experience gained by the operation of such plans, we would be in a better position to advise in the operation of a state-wide plan to include all communities.

The relief load in all communities has been so reduced during the past year that those remaining on the relief roster have a much higher incidence of illness than when the relief load was large, the cost of medical care being proportionately increased on a per capita basis. It is felt that with this reduced load a more satisfactory type of medical care may be given than was possible from the same amount of money appropriated for the care of a larger relief load, thus making the coming year an opportune time to interest municipalities in better medical care for the indigent.

There are believed to be several avenues of

approach by which the County Medical Societies or their Committees may interest municipalities in better care of the indigent:

- a. Personal contact with municipal officials, members of local assistance boards, and local relief directors.

- b. Arranging for formal conferences with local assistance boards for discussion of their particular problem.

- c. Attending the meetings of the County Units of the N. J. Association of Overseers of the Poor and Directors of Welfare. This Association has been organized on a state basis with County Units, thus corresponding to the organization of our State Medical Society.

At a meeting of our Committee on January 18, at Trenton, we asked Dr. Norman M. Scott, Medical Director of the Medical Service Administration of New Jersey, if he would further contact the Board of Freeholders of Camden and the Relief Commissioner of Newark with the view of putting our plan into effect in these municipalities this year. An estimate of the probable costs and a proposed plan of operation for Camden and Newark was submitted. Newark has been especially interested and on February 18 a meeting was held at the Academy of Medicine in Newark. At this meeting were representatives from our Committee, Dr. Scott, representatives from the City of Newark and a representative of the office of Mr. Charles R. Erdman, Jr., Director of Municipal Aid Administration of the State of New Jersey. A great deal of enthusiasm was shown and unless some unexpected hitch develops we are hopeful that the plan will be put into operation in Newark before the end of the year.

While the Medical and Hospital problem of the low-wage group is not as acute as it formerly was because of increased employment and higher wages due to the war, nevertheless, we are working toward perfecting our plan of having these people covered under the Medical Service Administration Plan of New Jersey, so that at the end of the war, with a probable depression, there will be no lag in carrying on this phase of our work.



## NURSING AND NURSING EDUCATION

A. CHARLES ZEHNDER, M.D., Chairman, Newark

The activities of the Committee on Nursing and Nursing Education during the past year have been mostly consultative with the Nursing Association and other committees of The Medical Society of New Jersey. With this objective in mind, the Chairman of the Nursing Committee sat in consultation with the American Red Cross, the Woman's Auxiliary, and other committees. The objective of these meetings was to increase the number of applicants for the courses given to Nurses, Nurses Aides, and others who could do nursing. The need

for these is very great, due to the war. At present, courses are being given by the American Red Cross in First Aid, Volunteer Nurses Aides, and Home Nursing. Courses are also being given by the regular nursing schools as refresher courses for graduate nurses. In other words, we are all endeavoring to stimulate applicants for these various courses, so as to increase the number of aides who can take the place of graduate nurses in hospitals and private nursing, thereby releasing graduate nurses for the Army and the Navy.

## PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown

Our Committee's chief effort during the past year has been the publication and distribution of the New Jersey Formulary, fourth edition. A copy was mailed to every member of the State Society and a reserved supply of copies is on hand in the Executive Office to take care of new members for perhaps a year or two. Copies of the Formulary have also been sent to internes in New Jersey hospitals and to hospital pharmacies.

mere distributor of ready-made medicines. This has been a factor in adding to the cost of medication. The chief purpose of the Formulary is to discourage physicians from prescribing over-priced, brand-controlled proprietary medicines. It is gratifying to note that this compend of formulas has become popular with many physicians in the State and reports would indicate that good use is being made of the book.

### NEW JERSEY FORMULARY

Instead of devising individual prescriptions, the physician has become more and more a

### MEDICAL DEFENSE

The Committee is most willing and anxious to assume any duties that may be assigned to us during this war period.

## WORKMEN'S COMPENSATION

WILLIAM K. HARRYMAN, M.D., Chairman, Hackensack

The program laid out by the Workmen's Compensation Committee for this present year is a continuation of the program as laid out by last year's Committee in an effort to complete some of the objectives that had not been completed last year. It was felt that due to the stress of the times it would be very unwise to undertake any extensive program.

The major objective of last year's program had been a recommended change in the Workmen's Compensation Law eliminating the fee named for hernia operations. It had been felt

that it was very unfair to set an exact fee in this particular type of injury where no other specific fees were mentioned throughout the Act and most cases worked a severe hardship on the hospital, the physician and the patient. This bill had been introduced and passed in the Assembly at the last session, but had never gotten out of Committee in the Senate. This Bill has now been introduced in the present Legislature in the Senate and is Senate Bill No. 55. We hope that this bill will be able to be passed this year.

Another of our objectives of the previous year completed in the early part of this year was the issuing of a bulletin in the September *Journal* of The Medical Society of New Jersey covering the salient portions of the Workmen's Compensation Law that would interest the practitioner with general recommendations for men who are not familiar with this Act. This was printed on a different colored paper and could be removed from the *Journal* and

be kept as a desk guide. This has been very well received and a number of copies have been ordered by the American Medical Association for distribution among the states.

We have also attempted to review any Bills introduced that would pertain to the Compensation Law and coöperate in all ways possible. While our work has not been extensive this year, I feel that we have made definite progress.

## ANNUAL REPORTS TO THE HOUSE OF DELEGATES

### MEDICAL PREPAREDNESS

CHARLES H. SCHLICHTER, M.D., Chairman, Elizabeth

At the meeting of the House of Delegates of the American Medical Association at New York City in June, 1940, the Surgeon General asked the A. M. A. to coöperate in the selection of the Medical Officers for the Army to be formed, and to assist in every way with the medical problems of the Army. This was done by forming a Medical Preparedness Committee of the American Medical Association on a national scale and then asking each State to form a similar committee and appoint a representative to the National Committee. Paralleling committees were appointed in each county of this State, with a chairman who represented the committee in an executive capacity.

#### SELECTIVE SERVICE

In September, 1940, a meeting of the State representatives to the Medical Preparedness Committee of the A. M. A. was held in Chicago. After a general discussion a program was adopted to be followed by the Committee. The first duty of the Committee in New Jersey was to assist the Director of Selective Service in the selection of medical men for the Selective Service Boards. At first there was confusion, and some men were appointed to the Selective Service Boards who were not M.D.'s or registered licensed physicians, and in a few instances some were men who had not practiced medicine for many years and were therefore out of touch with medical matters and for this reason they could not act as examiners of draftees. This confusion was finally cleared up at a conference with the then Governor A. Harry Moore, who, after this confer-

ence, stated that the Director of Selective Service would not appoint anyone as examiner on the Selective Service Boards unless he was passed by the Medical Preparedness Committee of the State Society. Your Medical Preparedness Committee handled this by referring each name to the chairman of the County Medical Preparedness Committee in which the doctor lived and receiving the approval of the chairman of the committee. We had to deal directly with the chairman and deal promptly, for it often happened that the night before a number of draftees were to be examined there would be a vacancy on this, that, or the other board and that vacancy had to be filled before nine the next morning. This necessitated a great deal of telephoning from the office of the Committee on Medical Preparedness. At no time did we fail, and at all times, almost without exception, were the Boards fully manned. A great deal of the credit is due the chairmen of the County Committees, whose work is gratefully acknowledged.

The work of the Committee, while voluminous, is largely of a detailed and administrative character, based upon policies originally adopted by the Committee. Our first task was when we were asked in 72 hours to have manned and in operation 202 Selective Service Boards, 10 Advisory Boards and physicians on the Appeal Boards. At the end of three days or 72 hours, Selective Service was notified and the names went to Washington. We feel that this was a fairly good job. There was criticism in some quarters because certain men and certain groups were not consulted. We did not

consult them because there was no time to do so, and writing letters or sending telegrams did not bring about the desired results, for very few were answered. While we began in this way we finally decided to deal almost entirely with the chairman of each County Committee; what he did was his business in dealing with the men in organized medicine in his community, but we got results. Of 100 per cent examined by the Local Board, 40 per cent are finally inducted. Of the remainder, 15 per cent are classified as 1B; that is, available for limited military service, but not inducted under present conditions. Twenty-five per cent are declared 4F, or disqualified for all military service. Twenty per cent constitute a miscellaneous group of men who should never have been referred for physical examination and who, when appearing before the Board, are deferred for occupational reasons, over age, dependency, etc. The total number of men examined by the Local Boards up to January 1, 1942, was 133,000. Of the selectees examined by Local Boards, 61,548, as of February 1, 1942, have appeared before the Induction Boards. Of these 51,827 were accepted for full military duty and are now in the Army. Nine thousand five hundred were rejected. Of those placed in the deferred list 1B, the majority were deferred for visual and dental defects. Of those rejected as physically disqualified for any military service, the causes were as follows: Neuropsychiatric, 20 per cent; genito-urinary and venereal, 14 per cent; visual deficiency, 10 per cent; dental deficiency, 9 per cent. In other words, the most common causes for deferment for men incapable of full military duty were visual and dental. Of men rejected as totally disqualified for any military service, the majority were for neuropsychiatric reasons and the second for venereal or genito-urinary diseases. Total rejections, 40 per cent Local Boards; 16 per cent Induction Boards—which equals 56 per cent.

Our profession in New Jersey need not stand aside for any in the United States. Our record in New Jersey, I have heard from Washington, is among the best if not the best in the country. Our record of accomplishment shows excellent medical examinations and a small percentage of men rejected by the Induction Boards.

The Medical Preparedness Committee, through its County Chairmen, has continued to function by supplying civilian men to man the Induction Boards. This was done at the request of the Surgeon Second Corps Area. I wish to speak of the very fine coöperation we have received from the County Chairmen in

this work, especially the chairman of Essex County, Dr. Roy Van Ness, and the chairman of Camden County, Dr. Henry B. Decker. These men have done a momentous job in assisting and practically taking over the work of the staffing by the civilian physicians, of the Induction Boards. This Board meets in Newark part of the month and part of the month in Camden. While the Committee on Medical Preparedness selects the civilian physicians to serve on the Boards, Dr. Van Ness and Dr. Decker have helped greatly in rounding up these men. The Committee on Medical Preparedness thanks Dr. Van Ness and Dr. Decker for their coöperation and sacrifice.

#### EXAMINATION FOR TUBERCULOSIS BY INDUCTION BOARDS

Another activity of the Committee on Medical Preparedness is, through arrangements with the Surgeon Second Corps Area, the x-raying of chests of all inductees at Camden and some at Newark. This work is paid for by the Federal Government and we have made a profit which I have dedicated to the Committee on Medical Preparedness. This money has been of great value to us in paying for extra clerical help, extra telephoning and for many things not provided the Committee in its budget from The Medical Society. It was no small job to get the material ready and we are greatly indebted to the tireless energy of Dr. Norman M. Scott. We are also indebted to Dr. Morrow, Dr. English, Dr. Collier, Dr. Runnels, Dr. Jaffin and other tuberculosis men who have willingly and at great sacrifice read the x-ray plates and given their expert opinion. Your government appreciates the work of the medical profession. Another activity of the Medical Preparedness Committee has been the matter of an Industrial Hygiene Unit in the State of New Jersey and also a Committee on Nutrition which is headed by Dr. Carlisle, who also represents the Committee on Nutrition Council of the State.

#### QUESTIONNAIRES

Another matter taken up by the Committee, and a very arduous one, was the work of getting out various surveys for the A. M. A. The first survey took months to get replies from the doctors in New Jersey. They were most tardy and non-responsive to the simple request of their National Organization and it was a long time before 50 per cent of the profession were willing to fill out the simple questionnaire. They seemed hesitant to answer, due to a fear of signing away their birth rights.



Some have complained because this work was done by the A. M. A. and not by the State of New Jersey itself. They felt that the records should have been taken by The Medical Society of New Jersey. Most of the men on our Committee do not agree with this. This was an obligation to the National Government and could only be properly performed by a national organization which had the clerical help and the set-up to follow through on this gigantic task.

#### REHABILITATION

There is now under consideration a program of rehabilitation of the men who have been rejected for service in the Army. The work of rehabilitating these men who have been rejected will be done by private physicians and will be paid for by the Federal Government. An experiment of this work is being done in two areas and reports are forthcoming. If we have these reports before the Annual Meeting we will further inform you on this matter by sending in a supplementary report.

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### CIVILIAN DEFENSE

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CHARLES H. SCHLICHTER, M.D., Chief Emergency Medical Services,  
New Jersey Defense Council

About a year ago Dr. Norman Scott and myself were asked to serve as members of the Committee on Health, Welfare and Recreation of the Civilian Defense Council of the State of New Jersey. We were asked so that we might be of use to the Council on all health matters and were definitely appointed as representing the medical profession. One or both of us attended every meeting of the Committee. In November, 1941, we were asked to become members of the staff of the New Jersey Defense Council for Emergency Medical Services. The Chairman of the Committee on Medical Preparedness was appointed Chief of Emergency Medical Services, with Dr. Norman M. Scott as Associate Chief. When we took this job over there had been practically nothing done to organize the Emergency Medical Services on the Defense Council in the local municipality. Some cities had done something but in the vast majority of the 568 municipalities nothing had been done. It must be remembered that this was not a Medical Society project but a project under the control of the State of New Jersey and the Federal Government. In New Jersey it was considered wise that each municipality be made a unit. This meant that each of the 568 municipalities in the State of New Jersey was by law ordered to organize a Defense Council. Each Defense Council has a Committee on Health and First Aid. It was recommended that this committee be headed by a physician. A great deal of work was done to organize the Emergency Medical Services and there was a great deal of misunderstanding and a great deal of jockeying for the limelight. Many wanted to take over the medical job. The New Jersey

Defense Council found it very difficult to deal directly with so many municipalities, and after consultation it was very wisely decided to establish five regional offices which were later increased to seven. Each regional office is headed by a Deputy Regional Chief of Emergency Medical Services who at his discretion may appoint as many aides as he finds necessary in the counties he controls. The following is a list of the names of the Deputy Regional Chiefs of Emergency Medical Services and the counties they control:

- District 1—Samuel A. Cosgrove, Counties of Hudson, Passaic, Bergen.
- District 2—Jacob Reiner, Counties of Union, Essex.
- District 3—Bernard McMahon, Counties of Morris, Sussex, Warren.
- District 4—Robert L. McKiernan, Counties of Middlesex, Somerset, Hunterdon, Mercer.
- District 5—William G. Herrman, Counties of Monmouth, Ocean.
- District 6—Robert A. Kilduffe, Counties of Atlantic, Cape May, Cumberland.
- District 7—Henry B. Decker, Counties of Burlington, Camden, Gloucester, Salem.

No one, unless he has been in our office in Trenton, can realize the enormous amount of work going through this office. The object in taking over this work was not only to render service to the people of the State and to our nation, but to keep in the hands of organized medicine all medical matters, and for this reason we are asking the wholehearted cooperation of each member of organized medicine in this Civilian Defense program.

## PROCUREMENT AND ASSIGNMENT SERVICE

CHARLES H. SCHLICHTER, M.D., Chairman, State Medical Committee,  
Procurement and Assignment Service

There has been established under the office of Emergency Management a Procurement and Assignment Service to coördinate the procurement of physicians, dentists, and veterinarians for all governmental, industrial and civilian requirements. There has been established in each State a Procurement and Assignment Service Committee, and in most States the Chairman of the Committee on Medical Preparedness was made Chairman of the Procurement and Assignment Service Committee. This was not so in all States, but in New Jersey the Chairman of the Committee on Medical Preparedness was appointed Chairman of the Procurement and Assignment Service Committee. Dr. Norman M. Scott was asked to serve as Associate Chairman. Dr. Harold Corbusier, Dr. David Allman and Dr. E. LeRoy Wood have been asked to also serve on this committee. All these men are members of the Committee on Medical Preparedness. In each county we have appointed a county adviser of Procurement and Assignment Service. This committee will be given a list of names of men who have enrolled with the Procurement and Assignment Service with a view of immediate commission in the Army or the Navy. We have been asked to check each of these names as to their dislocation at the present time. Where not available we have been told to make the reasons known. The list has been checked to the following extent, viz., they must be under 36, white, male, citizens, graduates of approved schools, with at least 12 months internship in an approved hospital, possessors of State licenses to practice, at present in the ethical practice of medicine and considered available for service in the Army or Navy. Upon receipt of this list, the men selected will be sent a

letter authorizing a physical examination and blanks to be filled out and returned. As stated before, the requirements are that he be under 36, white, male, citizen and available for dislocation at the present time.

At present we have in the United States 52,000 physicians under the age of 36. It is estimated that 30 per cent of these will not pass the physical examination. This leaves 37,000 available. Twenty-six thousand of these we must have immediately for the expanding Army of 3,600,000 men. This will leave a balance of 10,000 physicians in this age group for future expansion, and we may add to this about 5,000 physicians who are finishing their internship each year. If the Army expands to five or six million men we will be hard pressed to furnish physicians in this age group. We have been asked by some if they will be given posts commensurate with their training. Let me answer this in this way. The Surgeons General will attempt, in so far as it is possible, to place men in positions for which they are best suited, but the vast majority of men under thirty-six will be assigned to line troops. Men between the ages of 36-45 will be given positions in hospitals, on Nutrition Boards, Child Welfare work, etc. It is not beyond the limits of possibility that certain men over 45 will be called into the Service because of their special qualifications.

Procurement and Assignment is purely a federal agency. It is not under the A. M. A. but for liaison purposes, Procurement and Assignment has a branch office and officer in A. M. A. Headquarters so that we may utilize the records of the A. M. A. surveys on medical personnel.

## MEDICAL SERVICE ADMINISTRATION

ELTON W. LANCE, M.D., President, Rahway

The Board of Governors requests that this report be considered preliminary in character, to be supplemented by a complete report which will be presented to the House of Delegates at the Annual Meeting.

During the year our main effort has been expended in the development of three types of

plans: 1. A catastrophic illness plan, providing payment for medical services rendered bed patients in approved hospitals. 2. Plans for the medical care of the indigent in large municipalities. 3. Plans for the payment of medical care rendered sub-marginal rural families.

These are difficult, complicated problems,

which must be solved by a process of evolution. At times our progress in their solution has been very slow. As we seek a solution for each problem or complication, we reach no decision and take no step without the most careful consideration of each factor involved. All decisions must take into consideration the welfare of the profession, the welfare of the future of medicine, and of those who are or may be involved as patients. This has necessitated the holding of almost innumerable meetings; meetings of our Board of Governors, of our Executive Committee, of joint meetings with

representatives of the Hospital Plan of New Jersey, of meetings with labor organizations and industrial executives. No important step has been or will be made without the approval of The Medical Society of New Jersey.

In the present state of this evolutionary process, we believe we are making very definite progress in our solution of the problems involved. We feel that the retention of the Medical Service Administration as an agency of the medical profession is both practical and essential to the future welfare of medicine.

## STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., Secretary, Trenton

During the period of January to December, 1941, the Board examined 197 applicants for a license to practice medicine and surgery. Thirty-four of these applicants were licensed osteopaths who qualified for the examination by submitting evidence of having completed an acceptable post-graduate course of two years

in an approved college, or an acceptable internship of two years in an approved hospital, in accordance with the provisions of Section 45:9-14.1 of the Revised Statutes of New Jersey.

The Board also examined twenty-two applicants for a license to practice chiroprody.

TABLE I—SHOWING NUMBER OF CANDIDATES FOR THE 1941 EXAMINATIONS, CLASSIFIED AS GRADUATES OF MEDICAL COLLEGES IN THE UNITED STATES AND FOREIGN COUNTRIES AND ACCORDING TO CITIZENSHIP

	Citizens	*Non-citizens	Total	Passed	Failed	Not Issued
MEDICAL						
United States						
Graduates of Medical Schools . . . . .	106		106	101	5	
Licensed Osteopaths Who Qualified for a Full License to Practice Medicine and Surgery . . . . .	34		34	30	2	2
Poland . . . . .	1		1	1		
Canada . . . . .	4		4	4		
Italy . . . . .	29		29	10	19	
Austria . . . . .	2	5	7	2	5	
Germany . . . . .	3	1	4	3	1	
Hungary . . . . .	2	4	6		6	
Great Britain . . . . .	4		4	3	1	
Switzerland . . . . .	2		2	1	1	
CHIROPODY						
United States . . . . .	22		22	21	1	
	209	10	219	176	41	2

\*Those who were not citizens submitted Declaration of Intention to become an American citizen and were granted a license valid for six years from Date of Declaration.

One hundred and seven licenses were issued to applicants for endorsement of a license from another state who presented credentials to

prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.



TABLE II—*Showing Licentiates by Endorsement  
Classified as Graduates of Colleges in the  
United States and Foreign Countries*

Countries	Total
United States .....	100
Great Britain .....	3
Canada .....	4
	<hr/> 107

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals before a license was issued, also licenses issued to applicants in foreign countries that were submitted by candidates for the examination who were graduates of foreign medical schools, and licenses issued in the United States submitted by applicants for endorsement.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates practicing in the State is increasing or decreasing.

TABLE III—*Showing Number of Physicians and Surgeons, Osteopaths and Chiroprodists, Endorsed to Other States, the Number of Licentiates of Whose Death the Board Received a Record and the Number of Licenses Revoked.*

Physicians—Endorsed to Other States.....	36
Osteopaths—Endorsed to Other States.....	3
Chiroprodists—Endorsed to Other States....	1
Chiropractic License Restored .....	1
Midwifery License Revoked .....	3
Deceased Physicians .....	93
Deceased Osteopaths .....	3
	<hr/> 140

This table covers the physicians who died in New York City but does not include those who died in other parts of New York State, nor in other states of the United States, nor does it include the number of physicians who are licensed in other states as well as New Jersey who leave New Jersey to practice in some other state in which they are licensed.

An annual registration would give the Board accurate information in regard to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiroprody and midwifery do provide for an annual registration and our records show a decrease of nine in the number of chiroprodists that registered on November 1st, 1941, and a decrease of twenty-seven midwives for the same period.

## ENFORCEMENT

Petition for reinstatement of one license was granted and two were refused.

TABLE IV—*Summary of Board's Activities in  
Enforcing the Laws They Administer*

<i>Court Cases—Violation of Medical, Etc., Laws</i>	
Convicted, Pleaded Guilty or Settled....	32
Decision Reserved .....	4
Pending in the Courts .....	35
Chiroprodist—Failure to Register .....	1
	<hr/> 72
<i>Hearings Before Board</i>	
Medical:	
Revocation or Suspension Pending....	4
Petition for Reinstatement Refused ..	2
Midwifery:	
License Revoked .....	3
Chiropractic:	
Petition for Reinstatement Granted....	1
	<hr/> 10
	<hr/> 82

CLASSIFICATION OF INVESTIGATIONS AND  
INSPECTIONS

Type of Cases Investigated	No. Investigated
Druggists Practicing Medicine .....	39
Prescribing Herbs and Drugs .....	16
Medical Doctors .....	21
Unlicensed Chiropractors .....	71
Licensed Chiropractors Exceeding License..	12
Unlicensed Osteopaths .....	2
Licensed Osteopaths Exceeding License ...	3
Unlicensed Chiroprodist .....	1
Licensed Chiroprodist Exceeding License ...	2
Masseurs and Massage Treatments .....	11
Colonic Irrigations .....	3
Naturopaths .....	4
Optometrists Practicing Medicine .....	1
Cupping .....	1
Physio-therapists .....	5
Laying-On-of-Hands .....	2
Medical—Revocation .....	2
Midwifery Revocation .....	4
Miscellaneous .....	8
	<hr/> 208

## ANALYSIS OF INSPECTIONS AND INVESTIGATIONS

Total Number of Investigations and Inspections Made .....	208
Total Number of Visits Made and Treatments Received in Making the Investigations and Inspections .....	1,218
Average Number of Visits per Investigation..	5.8

## COUNTY SOCIETIES

### ATLANTIC

HARRY SUBIN, M.D., President, Atlantic City

The entrance of the United States into World War II heaped new problems and increased responsibilities upon the officers and members of all medical societies. Long before war was declared, the President of the Atlantic County Medical Society assembled a committee composed of Drs. Allman, Carrington and Kilduffe to map plans for local Civilian Defense and Emergency Medical Service. From this and subsequent meetings an Emergency Medical Service was gradually developed that has received commendation from both the Chief of the New Jersey State Emergency Medical Service, Dr. C. H. Schlichter, and the Chief Medical Officer of Civilian Defense, Dr. George Baehr.

Upon the recommendation of the Atlantic County Medical Society, Dr. Robert A. Kilduffe was appointed local Chief of Emergency Medical Service. Upon further recommendation, together with his outstanding qualifications and reputation as Chairman of the Atlantic County Medical Preparedness Committee, he was appointed Deputy Chief of Emergency Medical Service of the State of New Jersey for Zone No. 6.

While the work of Emergency Medical Service and Medical Preparedness proceeded at a rapid pace, the routine business of the Society was not disturbed. Outstanding speakers, among whom were Drs. C. H. Schlichter, I. S. Ravdin, Morris Fishbein, Joseph T. Beardwood, Marvin Fisher Jones, Leonard G. Rowntree, Edward A. Schumann, Tracy Jackson Putnam and others, addressed the monthly meetings.

The regular Post-Graduate Course, supervised by Dr. Robert Durham, was substituted by a refresher course in First Aid, War Medicine, and War Surgery. The first lecture, given by Dr. I. S. Ravdin on February 25, 1942, was attended by 250 members of the Medical and allied professions. This was the largest crowd yet assembled for a post-graduate lecture. Additional lectures are to be given by Dr. John J. Moorhead of New York, Dr. Frederick W. Waknitz of New York and Dr. David B. Allman.

During the past year the Society was able to attain relisting in the telephone book of medical men in contradistinction to osteopaths, by having M.D. placed after the name of the

regular physicians. This settled in part a long-standing difference between the Telephone Company and the Medical Society.

The Atlantic County Medical Society completed elaborate preparations for the entertainment of the State Medical Society in Atlantic City from April 21 to 23, 1942, and the American Medical Association, with Dr. William J. Carrington as local Chairman of Arrangements, for June, 1942.

The Program Committee, headed by Dr. Harold Davidson, met on several occasions with the President and arranged the monthly programs, as well as a Fifth Councilor District meeting held on March 13, 1942. Dr. S. Perkins, Dean of Jefferson Medical College, was the guest speaker. Other guests of the Society were State President, Dr. Tom Lewis; State Chief of Emergency Medical Service, Dr. C. H. Schlichter; Executive Officer of the State Society, Dr. LeRoy Wilkes; and the Presidents of the neighboring County Societies.

An exchange address system for men in service has been set up in the President's office and will be passed on to the President of 1942.

Among those men who have left for service out of Atlantic County during the past year are the following: Dr. Leonard Erber, Dr. Morris Gottlieb, Dr. Thomas Petinga, Dr. Harold Tuft, Dr. Milton C. Dobkin, Dr. Edward Loeb, Dr. Perry Frank, Dr. Joseph Weintrob, Dr. Stanley Burnell, Dr. J. E. Mischler and Dr. Howard Hudson.

The Membership Committee has been quite active in obtaining new members and checking on those eligible who have not yet made application. Four new members were admitted to the Society during 1941, bringing the total membership to 136. A drive for new members, under the auspices of Dr. Clarence Whims, promises to bring the few remaining eligibles into the Society before the end of the year.

Splendid work has been done by the Publicity and Publication Committee under the chairmanship of Dr. Sloan Stewart. He has been working in close correlation with the American Medical Association and has prepared a Health Section that has brought praise and exceptionally favorable comment from Dr. Morris Fishbein.

All committees have functioned with maxi-

mum smoothness and have produced gratifying results. Recommendations have been made by the chairman of almost each committee to improve organized medicine in this county, but their recommendations do not permit of complete review at this time.

Among the many accomplishments through committee research, however, are the establishment of an Orthoptic Clinic, the development of sight-saving classes in public schools, and arrangement, through physicians and nurses, for yearly eye examinations of school children by the Committee of Conservation of Vision headed by Dr. H. L. Harley.

The local Cancer Committee has been working jointly with the National Cancer Committee in propagandizing correct information as to the advances made in the study of this disease.

Dr. Samuel L. Salasin's Committee on Public Health reported the erection of a new hospital for tuberculosis in Northfield, N. J.; the opening of a new State Clinic for Tuberculosis in Atlantic City, and the starting of patch testing for tuberculosis in our local high schools.

The Venereal Disease Committee, of which Dr. Charles H. deT. Shivers is Chairman, has recommended that an ordinance be passed by the commissioners of Atlantic City to have all food handlers tested for venereal disease before being employed.

The very active Committee on Legislation, headed by Dr. David B. Allman, was successful in having a bill introduced by Senator Frank S. Farley to remove the \$150.00 limit

for hospital and surgical care of compensation hernia cases.

The Public Relations Committee, headed by Dr. C. Hyman, furnished speakers for the Kiwanis, church, civic and social groups. It has also been exceedingly active in working with benefit committees as, for example, the British War Relief. It has obtained and correlated information as to clinics and lay groups that has been of use to local governing bodies.

A follow-up system on rejectees was developed by Dr. William J. Carrington, and has been in effect for rehabilitating those draftees that were rejected for physical reasons by the local examining board. It is recommended that this committee continue to function similarly for those rejected by the Army Induction Board.

The Chairman of the Committee on Constitution and By-Laws, Dr. H. I. Silvers, commented favorably upon the stability of the Atlantic County Medical Society in his report which stipulated only one change made in the Constitution and By-Laws during the past year. This provided for associate membership and recommended close scanning of credentials of those making application for associate membership as a preliminary step to full membership.

Dr. Norman Scott, at the invitation of the President, presented the Medical Service Administration Plan at the February meeting, and answered questions raised by the members present. After considerable debate the Society voted favorably upon a resolution to endorse the plan.

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## BERGEN

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HARRISON B. WILSON, M.D., President, Hackensack

### AIMS AND OBJECTS OF THE CURRENT YEAR

As expressed in the President's formal message to the membership in June, 1941, these sum up to: (1) That all assistance be rendered our government during the period of unlimited emergency; (2) that the high standards of professional programs for our monthly meetings be maintained; (3) that we lend assistance to public health measures that are consistent with our responsibilities and at the same time maintain the dignity and status of private practice; (4) that we assist and aid in every way possible the work of the Woman's

Auxiliary of the Medical Society; (5) that a joint meeting with the Passaic County Medical Society be held and the subject of military preparedness be presented as it pertains to the medical profession.

A precedent was set when in November, 1941, the regular monthly meeting was waived and instead a dinner dance, arranged and promoted by the Woman's Auxiliary, was held. This proved a stepping stone to closer social contact among the doctors and also a closer cooperation between the Auxiliary and the County Society.



An attempt has been made to keep the programs on as high a professional scientific standard as possible, but limiting the subjects to the field of interest held by the general practitioners as a rule. Drs. Stimson, Bercovitz and Levy have addressed the Society and Drs. Amberson, Pack and Charles Hendee Smith will come in the succeeding months.

The joint meeting with the Passaic County Medical Society on medical preparedness was held in September.

#### MEMBERSHIP

The total regular membership of the year is 304; the junior membership 12; and the associate membership 9. Of these 11 were new members.

#### CHANGES IN THE BY-LAWS

The By-Laws were changed so that all candidates, including the nominee to the State Nominating Committee, be presented by the County Nominating Committee. Also that the County Nominating Committee should present its slate at the January Executive Committee meeting so that it could be presented to the membership at large at the first regular meeting in February and voted upon at the regular meeting in March. These changes make unnecessary a nomination of candidates to the State Nominating Committee from the floor and allow enough time before the State annual convention for election and instruction of newly elected officers and delegates.

#### WAR PREPAREDNESS

The Society accepted and discharged the responsibilities of setting up the medical examining boards and advisory boards in Bergen County as prescribed by the Selective Service Act. Hospitals were encouraged to set up emergency units and make preparations for abnormal increases in census in case of disaster. It was urged that first-aid courses be given for doctors in the various hospitals to familiarize the medical man with newer aspects of first-aid as made necessary by our newer concepts of war. It was urged that all doctors who found it possible should teach first-aid classes. It was suggested that this should rightfully be the responsibility of the medical profession and not the laity.

Of our membership there are known to be 22 in active service with the armed forces of the United States.

#### SPECIAL EVENT

It has been the privilege and honor of the Bergen County Medical Society to present as candidate for the Second Vice-Presidency of the State Society Dr. Samuel Alexander of Park Ridge, N. J. Dr. Alexander needs no introduction to the State because his untiring work on behalf of organized medicine and his worthwhile contributions as a member of the State Legislative Committee are commendable.

In considering the above factors, the County Society has functioned well. An attempt to apply the objects set forth has met with cooperation of the membership at large with many of the benefits intended being realized.

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## BURLINGTON

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DEAN H. LEFAVOR, M.D., President, Palmyra

In order to facilitate the evaluation of the Annual Report of the Burlington County Medical Society for the year 1941-42, it is presented herewith in semi-outline form.

#### AIMS AND OBJECTIVES OF THE CURRENT YEAR

1. To present a series of programs of especial interest to men in General Medical Practice, since the majority of our county members are general practitioners.
2. To start our meetings promptly, and end them as early as the business and scientific programs would permit.
3. To extend every courtesy to our speakers.

4. To extend ourselves to the utmost as individual members, and as a group, to assist in the War Effort and Defense Programs.

5. To do everything possible toward the dissemination of medical information among lay groups, both from a general health standpoint, and in defense units looking to us for leadership and guidance.

#### PLANS ADOPTED TO ACHIEVE THESE OBJECTIVES

1. Extra care was taken in choosing the Committee on Programs and Arrangements. I consider the post of Program Chairman to be the most important single appointment a County President has to make. Great credit

is due and hereby given to Dr. Freeman Metzger and his Committee for supplying a series of very interesting, timely, and instructive presentations by a singularly distinguished list of speakers.

2. The greatest obstacle to starting the meetings on time was overcome by an avowed determination on the part of the President to get himself to the appointed place at the appointed time, a record in itself.

We endeavored to get any and all argumentative discussions to the point of a motion on the floor as quickly as possible, thus disposing of the problem with the least amount of time-loss.

3. In order to make it possible for our speakers (many of whom came from a distance) to get to their subjects without sitting through what to most of them might have been an uninteresting and tiresome business session, a new system was inaugurated in our society this year.

After the opening of the meeting, the greeting of the guests, and the reading of the minutes of the previous meeting, the Program Chairman was called upon to present the scientific portion of the program, leaving the business meeting until the last. This plan was received with unfailing gratitude and praise by our speakers.

4. A. The Chairman of the Medical Defense Committee in each and every city and town in our county is a member of our County Society, thus making it possible for medical defense problems to have the benefit of discussion and opinions from all parts of the county in society sessions.

B. Dr. Harry L. Rogers, our County Medical Defense Chairman, has worked tirelessly in his efforts toward coördination of the local Medical Defense units.

5. A. A speaker was supplied for each of the two Kiwanis Clubs in our county in the Kiwanis Health Week in the Fall of 1941.

B. A number of members attended the Advanced Red Cross First Aid classes and acted as instructors in many lay First Aid classes.

#### NAMES OF OUTSTANDING SPEAKERS AT OUR MEETINGS, AND SUBJECTS DISCUSSED

1. September 11, 1941. A joint dinner-meeting with the Burlington County Bar Association was held at Log Cabin Lodge in Medford Lakes, N. J.

This has become an annual affair and the associations and contacts resulting therefrom have been mutually valuable to the members of both groups.

2. October 9, 1941. Richard Meade, Jr.,

M.D., Associate Surgeon, Episcopal Hospital, Philadelphia, Pa. Subject: "Recent Advances in Thoracic Surgery of Interest to General Practitioners".

3. November 13, 1941. Edward Weiss, M.D., Clinical Professor of Medicine, Temple University, Philadelphia, Pa. Subject: "Hypertension and Nephritis".

4. December 4, 1941. W. Wayne Babcock, M.D., Professor of Surgery, Temple University, Philadelphia, Pa. Subject: "Intestinal Malignancy".

5. January 8, 1942. John A. Kolmer, M.D., Professor of Chemotherapy, Temple University, Philadelphia, Pa. Subject: "The Sulfonamides in General Practice".

6. February 12, 1942. Edward A. Schumann, M.D., Philadelphia, Pa. Subject: "Some Obstetrical Dilemmas".

7. March 12, 1942. Color and sound motion pictures. Subject: "Recent Clinical Studies in Vitamin B Complex Therapy".

8. April 9, 1942. James S. Shipman, M.D., Chief of the Department of Eye Diseases, Cooper Hospital, Camden, N. J. Subject: "Treatment of Some Frequently Found Eye Problems in General Practice".

Total membership: 67.

New members elected to membership during the year: 2.

A fee schedule of minimum charges was adopted by the Society November 18, 1941.

Excellent reports were made by our State Society Committee Members, especially by Dr. Joseph Kuder's Committee on Welfare and Legislation, and Dr. Hammell Shipps' Committee on Public Health.

To date, only one of our members has been called to serve with the Armed Forces. Dr. Abraham B. Sand, of Burlington, N. J., was elected to membership on October 9, 1941, and left to join his unit the next day.

#### SUGGESTIONS FOR IMPROVEMENT IN THE CONDUCT OF COUNTY SOCIETY MEETINGS

1. That the Constitution and By-Laws on Procedure be changed to read that the scientific portion of the programs precede the Business Session.

2. That each County Society purchase or have made a xyphoid-high speaker's desk upon which the President and speakers may rest themselves and their notes while addressing the Society. The one we have was made-to-order by a cabinet-maker and presented to our Society by two of our members.

I should like to express my thanks to our Secretary, Dr. E. W. Rodman, for his reliable and efficient service, and helpful suggestions.

The best way to learn about war maneuvers is to be on the firing-line. The best way to learn about the value and benefits of State and County Medical Societies is to be the Pre-

siding Officer. Allow me to express my gratification for the privilege of having been permitted to see the road from the driver's seat this past year.

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## CAMDEN

DAVID F. BENTLEY, JR., M.D., President-Elect, Camden

Owing to the illness of our President, Dr. A. L. Stone, Dr. German, Secretary, has asked that I report to you briefly concerning the activities of the Camden County Medical Society during the past year.

We have had regular monthly meetings at which the scientific portions of the program have been carefully worked out, and were not only enjoyable, but also informative and instructive. The attendance has been excellent, although we wish that many more of our members could get to the meetings. Numerous subjects of medical interest as well as national defense have been on the programs.

Our Membership Committee has been fairly active, and all the younger men beginning practice have been elected into membership. Unfortunately we have lost a few of our older members by death, and are even now beginning to realize that a goodly number of our most active members are being called to duty with the armed forces.

During the year, a Committee for the Revision of the Constitution has remodeled our Constitution and By-Laws to conform with those of the State Society.

The activities of the State Welfare Committee have been carefully reported from time to

time, and the various phases of the Medical Service Plan have been presented, and the necessary action taken to assure our coöperation in this phase of the State Society's work.

Dr. Decker, Chairman of the Committee on Medical Preparedness, has been active in assisting with the many phases of medical defense, as well as the Procurement and Assignment Service. We have had a number of speakers on this line, and we feel that the free discussion of talks by Dr. Scott and others has clarified the stand of the local society in regard to both Civilian and National Defense matters.

We are carrying on with our usual course of Post-Graduate Lectures, which it has been customary for us to have in association with the Post-Graduate Division of Rutgers University. The course has been popular and self-supporting this year as in previous years.

Our Committee on Maternal Welfare has been active during the past year. Dr. West has called several meetings of the various groups interested for the discussion of maternal deaths, and other activities.

It would seem that this briefly covers the most important activities of the Society during the past year.

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## CAPE MAY

SAMUEL B. HUGHES, M.D., President, Wildwood

The Medical Society of Cape May County has had four meetings this year. Medical matters relating to our local Society have been the main problems considered.

Being a small group, an Executive Committee is considered unnecessary, since the general discussions are carried out by the whole Society and the results have been good. Each member feels that he has taken a personal part in the discussions.

So far only one of our members is in active service, although many of us are now engaged

in Selective Service work and other government activities; i. e., Coast Guard, Veterans Bureau, Venereal Disease, etc. Some of our members are undoubtedly going to miss the regular spring refresher course this year. In this locality we have substituted a course on the handling of injured as conducted in the various defense services. The objective of this course is excellent. Let us hope our need for its application in practice continues at a minimum.

As for the future, may it continue as the past, *Deum Volante*.



## CUMBERLAND

W. SHERMAN GARRISON, M.D., President, Cedarville

I submit the following report of the principal activities of the Medical Society of Cumberland County for the year 1941-42.

It has been a trying year for the physicians of many communities with the extra meetings necessitated by the defense program, and the extra patient load. However, we have held all our regular afternoon meetings and two interim evening meetings with a good attendance.

We have lost by death one member, Dr. E. N. Van Deusen of Vineland.

We have gained three new members, Dr. Thomas Sheppard of Millville, Dr. A. S. Gricco of Vineland and Dr. Leonard Scott of Bridgeton.

Five of our members, Dr. Charles Cunningham, Jr., Dr. Kenneth E. Corson, Dr. Leon J. Schwartz, Dr. Anthony Pino and Dr. Barney Lihn, are already in the Armed Forces.

The Program Committee has secured for us such well-known speakers as Dr. Catherine MacFarlane, Professor of Gynecology, Woman's Medical College; Dr. J. G. Cohen, Dr. Roscoe Teahan of the Jeane's Hospital, Dr. W. Emory Burnett of Temple, Dr. Mitchel Ruben of the Children's Hospital, Philadelphia, and Dr. Franklin Payne, well-known Gynecologist. They spoke to us on such sub-

jects as "Results in Cancer Research", "Roentgenography in Chest Diseases", "Clinical Aspects of Superficial Cancer", "Gall Bladder Disease", "The Newborn", and "Abnormal Menstrual Bleeding".

The Medical Service Administration Plan has been given a great deal of thought and consideration. Delegates attending the meetings at Trenton have brought detailed reports and special speakers have been invited to discuss it with us. Dr. LeRoy Wilkes, Executive Officer of the State Society, was with us at our October meeting and Dr. Norman M. Scott, Medical Director of Medical Service Administration, at our January meeting. This matter was finally brought up at our February meeting and Plan II was rejected by a majority vote of the Society. The members also at this meeting decided they did not have sufficient knowledge of the subject to vote approval of the Annual Registration Plan for Physicians.

The County is entirely organized for defense with its Casualty Stations equipped according to directions from the office of Civilian Defense. Chiefs of Emergency Medical Services have been appointed in all districts, nurses to assist them and a civilian First Aid Committee in each instance.

## ESSEX

FRANCIS C. WEBER, M.D., President, Newark

Early in the summer of 1941 Essex County planned a very active program for this year which, I am happy to say, has been carried out. At the meeting of Committee Chairmen, held in July, there was an interchange of ideas and correlation of the year's activities. The monthly Council meetings have been well attended and the Committees have been most coöperative.

An effort to arrange well-balanced and varied programs for the stated monthly meetings achieved the following calendar:

OCTOBER 9, 1941

"A Discussion of the Value of Blood and Plasma in Transfusion"—an illustrated address by Dr. Harold W. Jones, Associate Professor of Medicine, Jefferson Medical College of Philadelphia, Pa.

NOVEMBER 13, 1941

"Child Health in the Defense Program"—an address by Dr. Martha M. Eliot, Associate Chief, Children's Bureau, U. S. Department of Labor, Washington, D. C.

DECEMBER 18, 1941

Joint meeting with the Academy of Medicine of Northern New Jersey. "Demonstration of Pathological Specimens of Interest to Physicians and Surgeons, by Kodachrome Slides"—by Dr. Harrison S. Martland, Chief Medical Examiner of Essex County.

"1942 and After (?) or "Medicine's Inheritance of World War II"—an address by Dr. William H. Perkins, Dean of Jefferson Medical College, Philadelphia, Pa.

JANUARY 8, 1942

"The Practitioner's Surgery"—an illustrated address by Dr. W. Wayne Babcock, Professor of Surgery, Temple University, Philadelphia, Pa.

FEBRUARY 12, 1942

"The State Administrative Program"—an address by Dr. Elias J. Marsh, President-Elect of The Medical Society of New Jersey.

"The Current Trend Toward Organized Medical Services"—an address by Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey.

"Status of the Doctors in New Jersey as Observed by the State Medical Preparedness Committee"—an address by Col. Charles H. Schlichter, M.D., Chairman of the Medical Preparedness Committee of The Medical Society of New Jersey.

MARCH 12, 1942

"Some Recent Advances in Modern Urology"—an address by Dr. Oswald S. Lownesley, President of the American Urological Society. Introduction by Dr. Clarence R. O'Crowley, Assistant Professor of Urology, University of Pennsylvania.

APRIL 9, 1942

"Modern Therapeutics in Cardiology"—an illustrated address by Dr. William D. Stroud, Professor of Cardiology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

MAY 14, 1942

Annual Meeting.

The Child Welfare Committee has endeavored to center its work this year chiefly on the neo-natal period, in an attempt to decrease the neo-natal death rate which has been unchanged during the past three years. Plans for the establishment of rules for infant resuscitation have been made, and will be sent to the hospitals in Essex County in the near future. This Committee has instituted the practice of publishing an article on "Child Care" monthly in the Bulletin, and is continuing the work started last year on prematures. Through its efforts three hospitals in Newark have established premature units this year, namely Newark City, St. Michael's and St. James'.

The Maternal Welfare Committee continues to hold its very instructive monthly conferences on maternal deaths in Essex County. The efforts of this Committee will, no doubt, result in a reduction of the maternal death rate.

The Heart Committee arranged to conduct "Heart Week" from April 6 to 10, 1942. Speakers were supplied to organizations during this week, addressing them on various topics pertaining to heart disease. A symposium on heart conditions, with a demonstration of heart specimens and Kodachrome slides by Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, was presented at the Newark City Hospital.

The Lung Committee has been especially active, holding monthly conferences on diseases

of the chest at the various hospitals throughout the county, in conjunction with the staff meetings of the hospitals. Six such conferences have thus far been held, all of which were very instructive and well attended. The following prominent physicians were guest speakers at the conferences: Dr. James Alexander Miller, Dr. Grant Thorburn, Dr. H. W. Meyer, Dr. Bela Schick, Dr. Harry Wessler and Dr. George G. Ornstein, all of New York City.

The Hospitals and Medical Preparedness Committee has met every emergency. They coördinated the various hospital emergency teams and helped to supply the personnel for first-aid and casualty stations, and Selective Service Boards. In coöperation with the Post-Graduate Instruction Committee, they presented a series of lectures on traumatic medicine, which were exceedingly popular with our members, entitled as follows:

Emergency Medical Organization—Local  
Coördinating Units and Duties.  
Emergency Treatment of Burns.  
Shock and Hemorrhage.  
Fractures—Traction Splinting.  
Resuscitation—Blast Lung—Blast Injuries.  
War Gases.

Our Public Relations Committee has had a successful year, having carried on all of its usual activities and in addition, several special projects. The Press Bureau continues its weekly column in the Newark Evening News under the title "Timely Medical Topics", which is now running into its fourth year. Members of the Speakers Bureau have delivered many addresses to lay audiences comprising service clubs, school groups and other civic bodies. The Medical Social Work Subcommittee has appropriately dealt with problems arising in its field, namely contacts with social workers groups, the Specialists' Consulting Bureau for indigent patients confined to their homes, and similar activities. The Exhibit Committee presented a comprehensive exhibit composed of ten units on the subject of "Nutrition" at the Hotel Suburban, East Orange, during the week of February 9th to 16th. Fifteen hundred persons visited the exhibit and there were many expressions of appreciation and commendation from those who attended. The Woman's Auxiliary was most helpful in the arrangement and staffing of this exhibit. The Moving Picture Subcommittee expanded its activities considerably this year. Numerous films on medical subjects were presented to lay audiences in public schools and elsewhere throughout the county.

The special projects of the Public Relations Committee this year consisted of participation

in the New Jersey State Society's program presented to the Kiwanis Clubs of New Jersey during the month of October; presentation of six special programs to the Contemporary Club of Newark, and the arrangement and execution of the contribution of the Essex County Medical Society to "Nutrition Week", which was sponsored and arranged by the local chapter for the Oranges and Maplewood of the American Red Cross. This contribution consisted of the presentation of moving picture films on nutritional subjects in many of the schools of the Oranges, the assembly of the

exhibit on "Nutrition" at the Hotel Suburban, East Orange; the delivery of seven addresses before various groups in the Oranges and Maplewood, and the procurement of Dr. Howard W. Haggard of Yale University as the principal speaker at the final grand rally of the week at Orange High School on the night of February 16, 1942.

The Essex County Medical Society is co-operating with the City of Newark in planning for the improvement of medical care of the indigent, and while nothing definite can be said at this time, we can report progress.

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## GLOUCESTER

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F. G. WANDALL, M.D., President, Clayton

The Gloucester County Medical Society was very fortunate this year, as in past years, in having physicians important in their own fields of endeavor as speakers at the monthly meetings. Thus the latest methods and theories in all branches of surgery, obstetrics and general medicine have been brought to the members. These speakers included such eminent men as Dr. Hobart Reiman, Professor of Clinical Medicine of Jefferson Medical College; Dr. William Lemmon, Assistant Professor of Surgery at Jefferson Medical College; Dr. Harvey B. Mathews of Brooklyn, Professor of Obstetrics of the Long Island College Hospital; and Dr. Edward Strecker, Professor of Neurology of the School of Medicine, Pennsylvania University.

Due to the harmony existing between the Chairmen of committees and the members, the society has been able to accomplish several objectives. These I will discuss separately.

### MEDICAL SERVICE ADMINISTRATION

Through the efforts of Dr. Joseph Hughes, the Medical Service Plan was presented to the members. He spent a great deal of his time on this plan; however, the Society lacked seven members to make up the total 50 per cent of the eligible members required, and it was decided to leave it on an individual basis rather than the group subscription.

### PUBLIC RELATIONS

Dr. Louis K. Collins has efficiently carried out the duties of this committee, obtaining speakers for the many Parent-Teachers Associations, Boy Scout Troops, Kiwanis and Lions Clubs. Especially should he be commended for the work of obtaining speakers for all the Kiwanis Clubs in the county during the week

of October 5, 1941, on the subject "The American Way of Medicine".

### MEDICAL PREPAREDNESS

Dr. William Pedrick and his committee have had a very busy year due to war conditions. We are very grateful to Dr. Pedrick for his untiring energy and splendid results. Through his efforts the draft board situation of the three local boards in the county was ironed out to the satisfaction of the physicians and all concerned.

### MATERNAL WELFARE

Under the leadership of Dr. Harris Underwood this committee has functioned smoothly and with due interest to the local maternal welfare in the county.

### PUBLIC HEALTH

Dr. Herman Wright has very capably directed the work in this field.

### POST-GRADUATE

We have appreciated the efforts and vital interest of Dr. Diverty in the post-graduate work.

### PROGRAM

It was through the genuine interest of Dr. Clarence Bowersox and his committee that the annual social session was a complete success. There are many details of a banquet which make for the success of such an affair and nothing was forgotten. We even had the honor of having our State President as one of our guests.

Our society has fifty-one members to date. Two of our men are in the service of our country.



The questions of fees was settled in a diplomatic way by our capable secretary with a motion which was passed, for a general increase in fees.

A complete interest in all our meetings and the work of the society, by the large group of men attending meetings, speaks well for the continued success of the society.

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## HUDSON

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ANTHONY J. CONTY, M.D., President, Union City

The Hudson County Medical Society has had a most active and progressive year. The coöperation by the various committees was splendid and the members have taken a deep interest and whole-hearted participation in the Society's activities, both scientific and business, as well as social.

The Program Committee was successful in securing outstanding speakers to present interesting and timely subjects. The Scientific Program was varied and included the following:

*October 7, 1941:* "Evaluation of Experimental and Clinical Data in the Different Stages of Thyroid Disease with Emphasis on the Operative and Non-operative Types", by Dr. J. William Hinton, Associate Attending Surgeon, New York Post Graduate Hospital and Visiting Surgeon, Bellevue Hospital.

*November 5, 1941:* "Recognition and Management of Some Common Dermatoses", by Dr. Marion B. Sulzberger, Associate Professor of Dermatology, Post Graduate Medical School, Columbia University, and Lieutenant Commander, Medical Corps, United States Navy.

"Administrative Program and Presidential Greetings of Dr. Lewis", by Dr. Elias J. Marsh, President-Elect of The Medical Society of New Jersey.

"The Current Trend Toward Organized Medical Services", by Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey.

"The Distribution of Medical Services Through Medical Service Administration of New Jersey", by Dr. Norman M. Scott, Medical Director of the Medical Service Administration of New Jersey.

*December 2, 1941:* "Pathogenesis of Erythroblastosis Fetalis", by Dr. Philip Levine, Immunologist of Beth Israel Hospital, Newark.

"Prevention of Transfusion Accidents", by Dr. E. M. Katzin, Medical Director of Blood Transfusion Association.

"Clinical and Pathological Aspects", by Dr. Nicholas M. Alter, Pathologist, Margaret Hague Maternity Hospital.

*January 6, 1942:* "Cardinal Principles of Sulfonamide Therapy", by Dr. Harrison F. Flippen, Associate in Medicine, University of Pennsylvania.

*February 3, 1942:* "The Problem of Chronic Joint Disease", by Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical College, New York.

The Public Relations Committee has been particularly active during the past year and has proven useful in supplying speakers to the

various educational and fraternal organizations, such as the Parent-Teachers, Kiwanis and many others. Under their supervision also is our "Radio Health Forum", a weekly feature, where medical subjects of vital interest to the public are taken up and discussed freely. Judging by the number of letters received by the Radio Station, this feature appears to show increasing interest and appreciation by the public.

During this year, the members have deliberated much on the merits of the distribution and payment of medical services through the Medical Service Administration. The Society has agreed to participate, and has approved of the plan, providing for the payment of medical and surgical care rendered to subscribers while hospitalized, under combined coverage of the Hospitalization Service and the Medical Service Administration of New Jersey.

The Civilian Defense and Emergency Medical Service is delegated to the Deputy and Local Chiefs in this area, who have charge of all the activities relative thereto. They have received the approval and complete coöperation of the County Society.

Our Annual Banquet took place on St. Valentine's Day, February 14, 1942, and proved a grand get-together of our members and guests. In addition to excellent entertainment, we were privileged to have Dr. Perrin H. Long, Professor of Preventive Medicine, Johns Hopkins University. He had just returned from Pearl Harbor, Hawaii, and he gave us the first authentic appraisal of the use of the sulfonamide drugs in all types of casualties there. He told of how the medical and surgical personnel were on the alert and ready for any emergency, and they scored the world's greatest success in the treatment of war wounds and burns.

The current year has shown a steady increase in our membership, the highest in our history; excellent attendance at our meetings and a fine harmonious feeling of good fellowship among the members.

To the twenty-eight or more members who are now serving in the Armed Forces of the United States, we wish success and safe return.

## HUNTERDON

RAYMOND J. GERMAIN, M.D., President, High Bridge

The most important objective of the Hunterdon County Medical Society for the current year has been its war preparations. Hunterdon County has a total population of 35,000 people, largely rural. Having no hospitals, a temporary emergency hospital has been established at Clinton Farms, Clinton. Annandale Farms has made available 200 war-time beds. Twenty-seven Casualty Stations have been established throughout the county and approximately 45 First Aid Squads are in the process of preparation. This work has been greatly assisted by the Hunterdon County Chapter of the American Red Cross, Mr. Sidney Souter, Superintendent, Annandale Farms, Annandale, and Miss Edna Mahan, Superintendent, Clinton Farms, Clinton. One Surgical Team has been organized under the leadership of Dr. Robert Coleman.

Speakers at two of our meetings were: Dr. B. M. Hance, Gynecologist and Urologist of Easton, Pa., who gave a clear picture of the problem of sterility. Dr. Samuel B. English and Staff of Mt. Kipp Sanatorium presented a symposium on tuberculosis.

The By-Laws of the Hunterdon County Medical Society were revised and brought up to date to conform with the By-Laws of the State Society. One important change was that of our annual meeting date. Under the revised By-Laws it will be held in July instead of October.

Two of our members are serving with the Armed Forces and it is contemplated that several more will enter the services in the near future.

## MERCER

HAROLD C. COX, M.D., President, Hightstown

A resumé of the activities of the Mercer County Society during the year demonstrates conclusively that the scientific study of medicine has not been pushed aside by the many serious economic problems confronting the profession.

Several physicians of outstanding reputation appeared before the Society and addressed the membership on the subjects of "Diabetes", "Cardiac Affections" and "Nerve Disorders".

The Medical Service Administration, the Farm Security Plan and the intensive program outlined by President Lewis were ably discussed by Dr. Scott and President-Elect Marsh, the Society going on record as in favor of supporting all of these activities.

The remission of dues for men in service was thoroughly detailed by Treasurer North, and the Society moved to assess the remaining members accordingly.

The annual registration of physicians received a most interesting discussion, which

finally resulted in the Society endorsing the legislation.

The Society now has about 25 members serving in the Armed Forces, with the prospect of providing many more.

The outstanding accomplishment in relation to the necessary routine management of Society conduct was the adoption of a revised By-Laws and Constitution, for which the Society is greatly indebted to the conscientious effort manifested by the committee in charge of the revision.

Perfect harmony reigns within the conferences held by the several committees, as is evidenced by the complete reports submitted for action before the Society in its transaction of business.

The Entertainment Committee provided an excellent program of sports and recreation for the June outing, as well as a most enjoyable November banquet.

## MIDDLESEX

MATTHEW F. URBANSKI, M.D., President, Perth Amboy

The following is a resumé of the activities of the Middlesex County Medical Society during 1941:

In maintaining our close relationship with the allied professions, the May meeting was a joint meeting with the County Dental Society

at which time a paper on "A Continental Looks at America" was presented by Eric Kohler, M.D., D.D.S., former Professor of Oral Surgery at the University of Prague and now Exchange Professor at the University of Wisconsin.

In November a joint meeting was held with the County Pharmaceutical Society, the Medical Society being the guests of the Pharmacists. Speakers for the physicians were: Dr. R. J. Faulkingham, President of the Middlesex County Medical Society, and Dr. Thomas K. Lewis, President of The Medical Society of New Jersey. Dr. John H. Hoagland, President of the Middlesex County Pharmaceutical Society, and Dr. Robert P. Fischelis, First Vice-President of the New Jersey Pharmaceutical Association, spoke for the pharmacists. Rev. Dr. Samuel Steinmetz, Rector of St. Michael's Episcopal Church, Trenton, was the guest speaker. Approximately 175 were in attendance.

A Post-Graduate Education course beginning in April, 1941, and covering a period of six weeks, consisted in three lectures at the Perth Amboy General Hospital and three at St. Peter's General Hospital in New Brunswick.

Scientific programs of particular interest given throughout the year were "Sulfathiazole: Clinical Adaptation in Urology" by Dr. Robert L. McKiernan of New Brunswick; discussion led by Dr. G. E. Harrop and Dr. Harry B. Van Dyke of Squibbs Research Institute. "Curable Types of Heart Disease" by Dr. William G. Leaman, Jr., Professor of Cardiology, Women's Medical College, Philadelphia; discussion by Dr. Estelle E. Kleiber and Dr. John V. Smith. "The Practical Points in the Diagnosis and Treatment of Various Forms of Arthritis" by Dr. Bernard I. Comroe, Associate Professor of Medicine, University of

Pennsylvania, Philadelphia. "Fixation of Fractures of the Femoral Neck by the Moore Nail Method" by Dr. Nelson W. Cornell, Assistant Professor of Orthopedics and Assistant Surgeon at the New York Hospital. "The Modern Management of Some Gastro-Intestinal Problems, Mainly Massive G.-I. Hemorrhage, Pyloric Obstruction, Intestinal Obstruction, Ulcerative Colitis" by Dr. Kendall A. Elsom, Assistant Professor of Medicine, School of Medicine, U. of P., Philadelphia.

The National Foundation for Infantile Paralysis, through the Committee Chairman, reported it would render any type of treatment that is necessary and will provide consultations. Members were invited to contact the Chairman of the Foundation, Mr. Fitzgerald of Woodbridge.

In June the 125th Anniversary of the Founding of the Middlesex County Medical Society was celebrated. Representatives of the State Society and seventeen neighboring counties were present together with one hundred members from Middlesex. The program consisted of an inspection tour of the Walker-Gordon Farm at Plainsboro; dinner at the Farm with Mr. Henry W. Jeffers, Sr., President of the Walker-Gordon Company as host. Dr. William J. Carrington of Atlantic City was toastmaster; speakers were Dr. Faulkingham, President of Middlesex; Dr. Joseph H. Kler, Program Chairman; Dr. Thomas K. Lewis, President of the State Society, and Dr. Watson B. Morris, Junior Past President of the State Society.

The Annual Meeting of the Society was held in December. New Officers and Delegates were elected. Five associate and five regular members were admitted to membership. Mr. Melvin Whiteleather, Foreign Affairs Correspondent of the Philadelphia Evening Bulletin and Station KYW News Commentator, gave a talk on "The World Today".

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## MONMOUTH

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BARCLAY W. MOFFAT, M.D., President, Red Bank

The problems and objectives for the current year, as outlined in the first message to the Society, were presented as a continuation of the work of the Society in the past few years—such as coöperation in the Defense Program and the working out of the Medical Service Administration. It was also hoped that during the coming year the Society would be more closely integrated with the agencies engaged in social work in the county.

This latter aim has been accomplished by a greater representation of the membership on Social Service Committees. A pediatrician has been most active on the Nutrition Council of Monmouth County. The problems connected with the medical care for the indigent have been many, and have been admirably taken care of as in the past by the Committee. The personnel of the Society has become increasingly active in the work of the Crippled Chil-



dren Commission, and is represented on practically all the committees of the Monmouth County Organization for Social Service. That the attendance this year has been unusually large is due to the splendid work of the Program Committee which secured a speaker of national reputation for each meeting. The high-spot of the program was an extemporaneous address by the guest speaker, Dr. Charles Gordon Heyd, at the Annual Dinner.

As to the first of these objectives, the County has participated in the Medical Service Administration of the State Society. We were also most fortunate in having Dr. Herrman

to organize and coördinate a Defense Program which is said to be a model throughout the State. A special meeting of the Society was given over to a detailed explanation of the Defense Program which was reported in full in the County Bulletin. The Society is also planning a special course on the major phases of military surgery, to which outstanding military surgeons will be invited to guide the discussion.

In closing, may I express my thanks to the personnel of the Committees of the County Society, and to the officers of the State Society, whose work has made possible a successful year.

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## MORRIS

DANIEL W. TELLER, JR., M.D., President, Morristown

The program of the Morris County Medical Society for the year 1941-1942 has had two objectives. First: Fullest coöperation with the plan of National Defense. This has included the continued, complete coöperation in working with the Draft Board, assisting the Office of Civilian Defense wherever possible, working with the Red Cross in the establishing of a blood plasma bank and assisting the Board of Health in the collecting of blood at registration for draftees.

Second: This year the Morris County Medical Society embodied in its monthly program the six Rutgers Post-Graduate Lectures. This series has been given to the members of the society at no extra cost. This scientific program has been very well received.

Our program has included to date such outstanding medical authorities as Dr. Hugo Roesler, Cardiologist for the Department of Medicine, Temple University, Philadelphia, Pennsylvania; Dr. Philip Moen Stimson, Assistant Professor of Clinical Pediatrics, Cornell University Medical School, who spoke on the diagnosis and early treatment of anterior

poliomyelitis (this discussion included the "Sister Kenney" treatment); Dr. William Goldring, Associate Professor of Medicine of the New York Medical College, who spoke on the recent advances in diagnosis and treatment of nephritis and hypertension; Dr. John Scudder of Presbyterian Medical Center, New York City, New York, spoke on the modern treatment of shock. We were extremely fortunate in having Dr. Chester I. Ulmer of the State Professional Relations Committee and Dr. Robert Fischelis, Secretary and Chief Chemist of the Board of Pharmacy. They both discussed physicians, patients and prescriptions, in relation to the Fourth Edition of the New Jersey Formulary.

At meetings during the spring months orthopedics and chest surgery for tuberculosis will be discussed.

This year a Physicians Welfare Committee will be formed, the purpose of which is to assist in any way the families of physicians going in the army. This committee will also help those physicians who have had unfortunate financial reverses.

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## OCEAN

CARL H. MENGE, M.D., Vice-President, Toms River

The Ocean County Medical Society has held its regular meetings throughout the year. The members are endeavoring to play their full part in the activities connected with the war, both with the fighting forces and civilian de-

fense, in spite of the fact that the demands made upon their time by private patients have also increased. Dr. Ivory, our President, was called into active service at the beginning of this year.

The Hospital Service Plan of New Jersey and the advantages it offers to individuals in groups was set forth by Mr. Moniot at our November meeting. The Executive Officer, Dr. Wilkes, addressed us on the "Trends in the Practice of Medicine" at our mid-winter

meeting. Among our scientific speakers, Dr. Robert Sturr, Associate in Roentgenology in the Jefferson Medical College of Philadelphia, gave a very good talk on the "Evaluation of X-Ray Therapy in Medical Practice".

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## PASSAIC

SIGURD W. JOHNSEN, M.D., President, Passaic

The program of the Passaic County Medical Society for the past year has been directed chiefly towards coöperating in the efforts of the National Defense program.

Our Military Preparedness Committee, under the able leadership of Dr. Todd, has responded to every demand made upon it and has given invaluable aid in the setting up of the medical emergency services of the local defense councils in our county.

Our Post-Graduate Committee, under the leadership of Dr. Wayne Hall, has inaugurated a new feature of post-graduate education for our members. Instead of simply having a series of post-graduate lectures, a number of clinical courses have been given in our various

hospitals. These courses have emphasized practical work in the clinics rather than didactic lectures. The response on the part of our members has been exceedingly gratifying. Some of the courses were so popular they were repeated three times. We feel that this endeavor has been very successful and we have gone back to the idea of using our hospital clinics for post-graduate education and training of our younger members in practical fields of the various specialties.

Our membership now comprises a total of 405, including 21 new members added this year. To date 23 of our members are in active service with our armed forces and many more are preparing to go.

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## SALEM

EDGAR E. EVANS, M.D., President, Penns Grove

The Salem County Medical Society has held its regular meetings throughout the year, one feature of the meetings being the fact that they are moved about the county, providing both convenience to members and variety in meeting place. Meetings have been held at Greystone Inn, Woodstown; DuPont Country Club, Carneys Point, and elsewhere, and in connection with each meeting a dinner has been served.

The President presided at these meetings and some excellent speakers provided talks of interest and practical value to our men. Among the speakers have been Dr. Edwin Ristine of Camden, who spoke on the early diagnosis of gastro-intestinal carcinoma; Dr. H. P. Shippo, who gave an excellent paper for general practitioners on the subject of office gynecology; Miss Janet G. Armstrong, R.N., of the Children's Hospital, Philadelphia, who showed a film illustrating the production and preservation of pooled human serum, and mentioned the clinical use of such serum in emergency such as severe shock and burns, and also its

use in such communicable diseases as whooping cough, measles, scarlet fever, etc.

Several of our members are participating in the medical aspects of industry, and the men more recently engaged in this work who have not yet become members of our Society have been invited to our meetings and to join as associate members. The subject of medical supervision and care of the men employed in DuPont's in the analin dye industry has been discussed and the use of cystoscopic and laboratory tests to aid in the control of the hazards incident to certain portions of this work was discussed so that the men who might meet such cases would be aware of the symptoms produced by these hazards. Since this is part of our Civil Defense Program it has received, along with the other aspects of this important subject, great stress at our meetings during the year.

Our meetings have been well attended and the fullest coöperation of our Society in the work of the State Society and in the military and civil programs of the government is assured.

## SOMERSET

LEWIS C. FRITTS, M.D., President, Somerville

The Somerset County Medical Society has the distinction of being the first County Medical Society in the country to have completed its 125th year of existence. This Society can report a very successful year, with meetings regularly held and well attended.

Our membership at the beginning of the year totaled sixty-six, and we concluded the year with sixty-seven active members. Four new members were accepted, and three were dropped from the rolls, one by resignation and two because of nonpayment of dues. Two of our members, Dr. N. L. Heminway and Dr. W. S. Schram, are on active service with the U. S. Army Medical Corps. Another of our members, Dr. H. P. Snyder, is doing special work in the Virgin Islands.

The 125th Anniversary of the Society was fittingly celebrated at a dinner meeting held in the Raritan Valley Farms Inn in May. At this meeting we were honored by the presence as guests of Dr. Watson B. Morris, Dr. LeRoy Wilkes, and Dr. Barclay S. Fuhrmann, as representatives of The Medical Society of New Jersey. Three of our members, Drs. J. H. Cooper, F. McConaughy and T. H. Flynn, were presented with certificates bearing the Society Seal, attesting to fifty years or more in the practice of their profession in New Jersey. The presentation was made by Dr. Morris.

Several scientific programs of outstanding merit were presented to the Society. Dr. Joseph Stokes, of the University of Pennsylvania, spoke most entertainingly of his experiences in wartime France, as a health officer for

the American Friends Society and later as a representative of the Rockefeller Foundation.

Dr. Quigley, Executive Secretary of the State Society Committee on Legislation, spoke to us briefly on the occasion of our Annual Dinner Meeting, which was held at the Far Hills Inn in October.

In November we were addressed by Dr. H. B. Decker, Associate Professor of Dermatology at Jefferson College, who gave us a very interesting talk on dermatology.

We were also addressed by Dr. Robert A. Matthews, Assistant Professor of Psychiatry at Jefferson Medical College, who spoke most instructively and entertainingly upon the recognition and handling of common psychoneuroses.

Dr. Lancelot Ely, Past President of The Medical Society of New Jersey, also gave a most interesting account of his experiences as a delegate for the State Society to the meeting of the House of Delegates of the A. M. A., in Cleveland, which he attended as alternate for Dr. W. P. Eagleton.

It is probable that most of the routine business transacted by the Society holds no great interest for the membership of The Medical Society of New Jersey. We should, however, like to report that excellent work has been done by our Committee on Medical Preparedness, under the chairmanship of Dr. E. T. Flint, in formulating plans for emergency measures. It also may be of interest that the Society at its December meeting placed itself on record as opposing further participation in the Medical Service Administration Plan.

## SUSSEX

HERBERT M. AITKEN, M.D., President, Ogdensburg

With one exception, no local problem of major importance affecting medical practice in Sussex County has arisen during the past year. The exception relates to medical care rendered recipients of old age pensions. Payment in the past for medical services rendered pensioners has been very difficult to obtain. A committee headed by Dr. Martin Kirschner of Vernon was appointed to investigate the situation. As a result of the committee's work we have a contract with the Sussex County Welfare Board, an agent of the Federal Old Age Pen-

sion System, which is proving satisfactory to the Board and doctors alike. The contract, in essence, provides the following: When a doctor first attends a pensioner he at once sends a report to the Board on a form supplied by it giving, among other things, name of patient, diagnosis and probable length of treatment. The Board acknowledges the notice and gives authorization for treatment beyond the first visit. When the Board sends the pensioner his next monthly check the cost of medical care rendered is added to the usual stipend



and the pensioner is instructed to pay the doctor. Because of Federal law there is no way of forcing the pensioner to make this payment, but so far there has been little trouble in this respect. At the end of each month the doctor sends a list of the names of pensioners he has treated, along with charges made, to a committee of doctors from the Society, who pass on the fairness of the bills and forward them to the Welfare Board with recommendation that payment be made. Charges for ordinary office and house visits are standardized in the contract. Free choice of physicians is permitted. The contract is not valid for services rendered pensioners admitted to hospitals, since these, on admission, become county cases. As a whole the plan is working well. The main difficulty has been to get the doctors to send preliminary reports and monthly statements promptly and correctly. Failure to do so, however, works only to the disadvantage of the doctor, since he cannot expect payment otherwise.

So far only one of our members, Dr. August Groeschel of Sussex, is in military service. However, nearly every doctor in the county is actively participating in some manner in the war effort. Many of our communities have

only one physician and these of course bear the full burden of directing the health and first aid activities of Civilian Defense in their towns. Classes in first aid, given by physicians, have been completed in most communities, and it is felt that Sussex County will soon be able to cope medically with any disaster.

Last year, under the leadership of Dr. J. H. Spencer of Franklin, members of the Society contributed funds sufficient to send two completely equipped surgical kits to England to aid in the care of injured civilians there.

Under the able direction of Dr. Kirschner, the revision of our constitution and by-laws continues. Each new article is being discussed at regular meetings so as to permit every member to contribute suggestions and comments.

Five new members were elected to the Society last year, bringing our total membership to twenty-nine. One application for membership is pending.

Approval of the changes in the Medical Service Plan is expected at our next meeting.

So far we have not had the pleasure of a visit from any of the State Society officers, but are anticipating a visit from our Second Vice-President, Dr. Londrigan, at our March meeting.

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## UNION

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LORRIMER B. ARMSTRONG, M.D., President, Westfield

In 1940 as our various committees took up their work, "Defense-Minded" seemed an idea apparent only to a very few of us. Early in 1941, after our Medical Defense Committee had helped to establish the local examining boards, an active coöperation between the Medical Advisory Board and the Federal and State authorities and had ascertained the available facilities in Union County in case of emergencies and military need, many of us realized how "Defense-Minded" was beginning to apply in our particular group. With the uncertainty of our country's position in world affairs, we realized that in the event of United States participation in the World War we had to be better equipped as a profession in order to advise our communities in matters pertaining to civilian preparedness.

In June, 1941, we considered preparedness for war so essential that we planned the Fourth Annual Fall Clinical Conference of The Medical Society of New Jersey, the morning session to center around industrial medi-

cine, to give us a realization of the gigantic task involved, not merely from our professional point of view but from the standpoint of defense preparedness; the evening speaker to be a well-known commentator who would give us the most pertinent facts of the world's situation. December 3, 1941, was a day well remembered by the many physicians who came to Elizabeth for the conference. Seven large industries welcomed us and provided valuable medical and industrial information. In the evening, Dr. H. van Zile Hyde, Chief Medical Officer of the Second Defense Area, emphasized the gravity of the present international situation and Johannes Steel, distinguished radio commentator, in no uncertain terms, with a clear realistic interpretation of "World Conditions", prepared us well for the events of December 7, 1941.

On February 18, 1942 in Elizabeth, the County Medical Society through its Deputy Chief of Emergency Medical Service District No. 2, had the privilege of presenting Profes-

sor James M. Mackintosh, Gas Prophylaxis Officer of Great Britain, to the medical profession of New Jersey. He gave us a vivid picture in graphic terms of the practical application of medical preparedness in relationship to Civilian Defense. For seven months many of our members have been conducting lay classes in Red Cross First Aid throughout the county. The Elizabeth hospitals conducted for the profession a course of five lectures in emergency care, the first given by Dr. Fred W. Bancroft, President of the New York Surgical Society.

The concerted action of individual groups to recognize and correct social welfare problems has continued to grow and with the impetus of a single-minded objective—"Victory", all organized community groups are now working together with a cooperation almost unbelievable in its achievement. Civilian Defense is the purpose around which all efforts must now center. An annual health examination for every person has long been sponsored by The Medical Society, but with the increased demand for good health as an active agent in Civilian Defense, it is now of paramount importance. The general practitioner received valuable advice in preventive medicine from Dr. Norman Jolliffe, who spoke to our society on "The Most Recent Clinical Applications of Vitamine Therapy". To educate the lay person to the necessity of nutrition requirements as a defense measure in the establishment of good health, a two-day county conference, "Conservation for Victory", was held in Elizabeth February 25-26, 1942, sponsored by the Union County Nutrition Council, Elizabeth Consumers Interest Committee and the Union County Extension Service in Home Economics. Our Executive Secretary, as Chairman of the second morning conference, presented one of our industrial physicians, who clearly outlined to a large group of women, active community leaders, the necessity of an adequate nutritional standard for each family member and stressed the point that every homemaker in her daily planning must use correct nutritional information. He indicated the increased physical and mental stress apparent in all types of defense work, occurring in both workers and executives, and gave practical suggestions

for the correction of existing faults. It is only through this type of program that Civilian Defense will be able to develop and become a working part of our daily life.

Serving on the Board of the Council of Social Agencies, on the Health Committee of the Chamber of Commerce and on the Union County Nutritional Council, our Executive Secretary has been in very close contact with all the work being carried on by these groups. She has thus had the opportunity of keeping well informed on community problems and their treatment. The County Advisory Committee to the Union County Welfare Board and the Visiting Nurse Association have been working in close cooperation on the existing problems as they have presented themselves. The Women's Field Army for the Control of Cancer in Union County has been firmly organized in the past few months with the help of our Cancer Committee and has presented its first sponsored program. Our Professional Guild of Union County, reorganized in 1939, is now a recognized part of the State Conference of Allied Medical Professions. This Guild can be a strong factor for allied professional groups in matters of public opinion. This year the Executive Office has functioned in an increased capacity in distributing medical information. Our Bulletin circulation now reaches eleven states. By interpretation of the economic relationship between the patient and his doctor, the Medical Service Bureau has continued to promote closer professional and business ties.

Twenty-three Union County members are now serving in our Armed Forces. We have heard from one in Honolulu and one in Ireland. For those of us who remain at home to carry out to the best of our ability, the development of Civilian Defense is our job at the moment, being fully aware of the sacrifices these men have made and are making to protect our way of life. A better interpretation and adjustment of civic problems, both in relationship to wartime emergencies and the ever present social problems, has most definitely been established by the demands placed on professional and laymen alike in this single-mindedness of purpose—"Victory".

## WARREN

RALPH M. L. BUCHANAN, M.D., President, Phillipsburg

The past year has been a trying year for physicians of many communities. Warren County has had its share of problems to solve. On a whole, these have been met and dealt with in an adequate manner.

The aims and objectives of the current year all centered around "Civilian Defense". In time of war, as well as in time of peace, it is the duty of all medical societies to protect the public against all health hazards. We are now at war and many disastrous conditions are possible. Any air raid in Warren County could destroy our water system or pollute this system with sewerage. In this way we may have an epidemic or epidemics of many preventable diseases, such as: typhoid, diphtheria, smallpox and scarlet fever. Hence, it is especially important at this time that we physicians of Warren County advocate and urge immediate immunizations of these preventable diseases.

### MEMBERSHIP AND ATTENDANCE

During the past year two new members were added to the Society's roster. One transfer was given. There were no deaths.

Except for one or two meetings when the weather was inclement, attendance was above the average. Perfect harmony and a most sincere and coöperative attitude pervade the entire membership, and the President takes great pleasure in expressing his appreciation of this spirit, demonstrated at the meetings so far held this year.

### SCIENTIFIC

A variety of programs have been presented during the past year, ranging from formal papers by distinguished physicians to informal symposiums. One symposium brought together the various welfare organizations of the county, Board of Trustees of our one local and only County Hospital and physicians. Through this meeting a very successful drive was started which will result in the reconstruction and enlargement of our own Warren Hospital. Ground will be broken some time in March.

### SPECIAL EVENT

Dr. G. W. Cummins, a member of the Warren County Medical Society, was honored on

November 13, 1941, at a dinner given in Belvidere in commemoration of his having served his patients and the profession for half a century, forty years of which he has served as Treasurer of our Society. Dr. Thomas K. Lewis, President of The Medical Society of New Jersey; Dr. William Costello, Chairman of the Board of Trustees; Dr. Joseph Londrigan, Second Vice-President of The Medical Society; Dr. Vincent P. Butler, Councilor of our district, and Dr. L. A. Wilkes, Executive Officer of the Society, were guests at the meeting.

Dr. Harry Bossard presented Dr. Cummins with a certificate and gold watch-charm. Arrangements were also made by The Warren County Medical Society to provide life membership for Dr. Cummins in the State and National Societies.

### POST-GRADUATE EDUCATION

Although our Society is small, it is gratifying to note the number of our membership who have faithfully attended the Morris County Post-Graduate Course in Medicine. The entire cost was absorbed by our friendly neighbor. Series of six lectures was given monthly at Greystone Park, Morris Plains.

### CIVILIAN DEFENSE

Each city, town and township of Warren County has set up its own Defense Committee. All are working in perfect coöperation and harmony. Although the average age of most of the physicians of Warren County is under 37, none have been called to active service. Several have already applied for commissions and are waiting instructions.

### HARMONY AND CO-OPERATION

"Harmony and Coöperation" has been the motto of Warren County Medical Society, both with the State Society, and within our own organization. The spirit of harmony has prevailed and has made the committee machinery function smoothly and efficiently. We of Warren County pledge further coöperation with the State Medical Society and with the other component Societies throughout the State.



## AN ECHO FROM THE 1924 ANNUAL MEETING



Through the kindness of Dr. Samuel Barbash of Atlantic City, the above picture was furnished for inclusion in the Convention Number of *The Journal*. The characters are familiar to many of you and the actors themselves are known to many more of our members.

Dr. Eagleton was President of The Medical Society of New Jersey in 1924, and the ladies of the local entertainment committee for the Annual Meeting in Atlantic City that year presented a sketch portraying a family album, each page of which disclosed a living picture of a well-known member of the Society in character, i. e., farmer, soldier, etc.

The scene was a doctor's home, and his daughter displayed to the audience the family album, page by page. As each character appeared she gave a brief farcical biography of the member. The ladies in the picture were members of the Entertainment Committee.

The Cast. Standing, left to right: Dr. E. H. Harvey, Atlantic City (deceased); Dr. Alexander McAllister, Camden; Dr. Henry A. Cotton, Trenton (deceased); Dr. Edward J. Ill, Newark; Dr. H. L. Harley, Atlantic City; Dr. W. Blair Stewart, Atlantic City (deceased); Dr. William Olmstead, Trenton. Kneeling, left to right: Dr. Samuel Barbash, Atlantic City; Dr. M. W. Reddan, Trenton (deceased); Dr. Wells P. Eagleton, Newark; Dr. Frank W. Pinneo, Newark (deceased); Dr. David C. English, New Brunswick (deceased).

The ladies—standing, left to right: Mrs. E. H. Harvey, Atlantic City; Mrs. Samuel Barbash, Atlantic City (deceased), and kneeling, Mrs. Milton Ireland, Atlantic City.

The social features of the Annual Meeting have always been among the high-lights of the meetings, and the ladies have been in large measure responsible for their excellence.

## REFERENCE COMMITTEES

### Reference Committee "A" to consider reports of:

The President  
The Board of Trustees  
The President-Elect  
The Secretary  
The Judicial Council  
The Executive Officer

C. Byron Blaisdell, Chm. .... Monmouth County  
Irving Okin ..... Passaic  
Harry N. Comando ..... Essex  
James H. Mason ..... Atlantic  
Vincent P. Butler ..... Hudson  
Meets Tuesday, April 21, 1942, 8:00 p. m.  
Tower Room I, 13th Floor

### Reference Committee "B" to consider reports of:

The Finance and Budget Committee  
The Treasurer  
The Publication Committee

Hilton S. Read, Chairman .... Atlantic County  
D. Leo Haggerty ..... Mercer  
J. Lawrence Evans ..... Hudson  
Robert E. Watkins ..... Monmouth  
Bernard C. McMahon ..... Morris  
Meets Tuesday, April 21, 1942, 8:00 p. m.  
Tower Room II, 13th Floor

### Reference Committee "C" to consider reports of:

The Medical Preparedness Committee  
The Medical Service Administration

James F. Norton, Chairman ... Hudson County  
Frederic W. Lathrop ..... Union  
David F. Bentley, Jr. .... Camden  
E. LeRoy Wood ..... Essex  
G. Barton Barlow ..... Bergen  
Meets Tuesday, April 21, 1942, 8:00 p. m.  
Tower Room III, 13th Floor

### Reference Committee "D" to consider reports of:

The Welfare Committee  
The Post-Graduate Education Committee  
The Medical Defense and Insurance Committee  
The State Board of Medical Examiners

Robert S. Gamon, Chairman ... Camden County  
F. Clyde Bowers ..... Morris  
Spencer T. Snedecor ..... Bergen  
Hammell P. Shipps ..... Burlington  
Ralph J. Faulkingham ..... Middlesex  
Meets Tuesday, April 21, 1942, 8:00 p. m.  
Green Room, 13th Floor

### Reference Committee on Credentials

Elias J. Marsh, Chairman .... Passaic County  
Alfred Stahl, Secretary, Ex-officio .... Essex  
George J. Young, Treasurer, Ex-officio . Morris  
Meets each morning at Registration Desk

### Reference Committee on Resolutions and Memorials

Wendell J. Burkett, Chm. ... Gloucester County  
D. Ward Scanlan ..... Atlantic  
Herschel Pettit ..... Cape May  
Joseph R. Morrow ..... Bergen  
Raymond A. Taylor ..... Ocean  
Meets at call of Chairman

### Reference Committee on Constitution and By-Laws

Samuel Alexander, Chairman ... Bergen County  
Robert A. Kilduffe ..... Atlantic  
John H. Rowland ..... Middlesex  
A. Dunbar Hutchinson ..... Mercer  
Francis C. Weber ..... Essex  
Meets at call of Chairman

### Reference Committee on Miscellaneous Business to also consider reports of:

The Place and Date of the 1943 Annual Meeting  
The Advisory Committee to the Woman's Auxiliary

Chester I. Ulmer, Chm. .... Gloucester County  
Jesse McCall ..... Sussex  
Watson B. Morris ..... Union  
J. Irving Fort ..... Essex  
Joseph F. Londrigan ..... Hudson  
Meets at call of Chairman

## WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

### FIFTEENTH ANNUAL MEETING

#### Tuesday, April 21, 1942

9:00 a. m.—Registration—Luncheon and Dinner  
Tickets  
Exhibit Hall, Lounge Floor  
1:00 p. m.—Executive Board Meeting  
Solarium, Lounge Floor  
4:00 p. m.—Rolling Chair Ride for Ladies (no fee)  
In event of inclement weather, cards in lieu  
of Chair Ride.

#### Wednesday, April 22, 1942

9:30 a. m.—Business Session  
Solarium, Lounge Floor

1:00 p. m.—Luncheon honoring Auxiliary President (Fee \$2.00)  
Rutland Room, 1st Floor  
2:30 p. m.—Business Session, continued  
Solarium, Lounge Floor  
4:00 p. m.—Art and Hobby Tea  
Sun Porch, Lounge Floor  
7:30 p. m.—President's Banquet (Fee \$3.00)  
Rutland Room, Lounge Floor  
10:30 p. m.—Dance  
Rutland Room, Lounge Floor

#### Thursday, April 23, 1942

10:30 a. m.—New Executive Board Meeting  
Solarium, Lounge Floor

# THE 176<sup>th</sup> ANNUAL MEETING

## of The Medical Society of New Jersey

### EXHIBITS:

**Scientific**—Vernon Room, Lounge Floor  
**Scientific Motion Picture Theatre**—Pavillon, Lounge Floor  
**Technical**—Parlor, Lounge Floor  
**Art, Hobby and Medical History**—Sun Porch, Lounge Floor

### SCHEDULE OF EVENTS

#### Monday, April 20, 1942

2:00 p.m.—Registration opens

All officers, delegates, members of component County Societies, guests, and exhibitors are requested to register at the Registration Desk in the Exhibit Hall on the Lounge Floor, immediately upon arrival.

8:00 p.m.—Board of Trustees' Meeting  
Mandarin Room, 13th Floor

8:30 p.m.—Judicial Councilors' Meeting  
Green Room, 13th Floor

#### Tuesday, April 21, 1942

10:00 a.m.—Inspection of Exhibits

11:00 a.m.—House of Delegates  
Garden Room, Lounge Floor

1:00 p.m.—Auxiliary Executive Board Meeting  
Solarium, Lounge Floor

2:00 p.m.—General Medical Session  
Garden Room, Lounge Floor

4:00 p.m.—Auxiliary Rolling Chair Ride (no fee)

5:00 p.m.—Inspection of Exhibits

8:00 p.m.—Reference Committee Meetings  
Reference Committee "A"  
Tower Room I, 13th Floor

Reference Committee "B"  
Tower Room II, 13th Floor

Reference Committee "C"  
Tower Room III, 13th Floor

Reference Committee "D"  
Green Room, 13th Floor

8:30 p.m.—Nominating Committee Meeting  
Mandarin Room, 13th Floor

#### Wednesday, April 22, 1942

9:00 a.m.—Inspection of Exhibits

9:30 a.m.—Auxiliary Business Session  
Solarium, Lounge Floor

10:00 a.m.—Scientific Section Meetings  
Eye, Ear, Nose and Throat  
Mandarin Room, 13th Floor  
Gastro-Enterology  
Viking Room, 13th Floor

Medicine  
Garden Room, Lounge Floor

Obstetrics and Gynecology  
Roberts Room, Chalfonte

Pediatrics  
Bakewell Room, 1st Floor

Radiology  
Tower Room, 13th Floor

Surgery  
Benjamin West Room, 13th Floor

12:30 p.m.—House of Delegates (Election)  
Garden Room, Lounge Floor

1:00 p.m.—Luncheon—Maternal Welfare Committee Field Physicians  
Gold Room, Chalfonte

1:00 p.m.—Auxiliary Luncheon (Fee \$2.00)  
Rutland Room, 1st Floor

2:00 p.m.—General Surgical Session  
Garden Room, Lounge Floor

2:30 p.m.—Auxiliary Business Session  
Solarium, Lounge Floor

4:00 p.m.—Art and Hobby Tea  
Sun Porch, Lounge Floor

5:00 p.m.—Inspection of Exhibits

7:30 p.m.—President's Banquet (Fee \$3.00)  
Rutland Room, 1st Floor

10:30 p.m.—Dance  
Rutland Room, 1st Floor

#### Thursday, April 23, 1942

9:00 a.m.—Inspection of Exhibits

10:00 a.m.—House of Delegates  
Garden Room, Lounge Floor

10:30 a.m.—Auxiliary Executive Board Meeting  
Solarium, Lounge Floor



## GENERAL MEDICAL SESSION

Tuesday Afternoon, April 21, 1942

Garden Room, Lounge Floor

2:00 P. M.

Chemotherapy Under War Time Conditions  
John S. Lockwood, M.D., University of Pennsylvania, Philadelphia

2:30 P. M.

Public Health in Time of War  
Ralph C. Williams, Senior Surgeon, United States Public Health Service, New York City

3:00 P. M.

Epidemiology in War Time  
Joseph A. Bell, P. A. Surgeon, United States Public Health Service, Washington, D. C.

3:30 P. M.

Plasma and Blood Banks in War Time  
Eugene M. Katzin, M.D., Newark

3:50 P. M.

Neuroses and Psychoses in War Time  
Clarence M. Tippe, M.D., Medical Officer, Veterans' Administration, Asbury Park

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## GENERAL SURGICAL SESSION

Wednesday Afternoon, April 22, 1942

Garden Room, Lounge Floor

2:00 P. M.

Chemotherapy in War Time Surgery \*  
F. R. Hook, Captain, Medical Corps, United States Navy; Chief of Surgical Service, Naval Hospital, National Naval Medical Center, Bethesda, Md.

2:30 P. M.

Plastic Surgery in War Time  
George Morris Dorrance, M.D., Philadelphia

3:00 P. M.

The Treatment of War Wounds of the Thorax  
George N. J. Sommer, Jr., Captain, Medical Corps, United States Army, Tilton General Hospital, Fort Dix

3:20 P. M.

The Treatment of Compound Fractures in War Time  
Irvin E. Deibert, M.D., Camden

3:40 P. M.

The Care and Treatment of Burns in War Time  
Royal A. Schaaf, M.D., Newark

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## SECTION MEETINGS

Wednesday Morning, April 22, 1942

### EYE, EAR, NOSE AND THROAT

WILLIAM K. CAMPBELL, M.D., Chairman  
R. WINFIELD BAESEMAN, M.D., Secretary  
Mandarin Room, 13th Floor

#### SYMPOSIUM ON SYPHILIS AND ITS RELATION TO EYE, EAR, NOSE AND THROAT

10:00 A. M.

Chiasm and Tract Lesions,  
Irvin Levy, M.D., Trenton

10:15 A. M.

Diseases of the Cornea  
Elbert S. Sherman, M.D., Newark

10:30 A. M.

Fundus Lesions  
Andrew Rados, M.D., Newark

10:45 A. M.

The Iris and Uveal Tract  
George P. Meyer, M.D., Camden

11:00 A. M.

Involvement of the Larynx  
Earl LeRoy Wood, M.D., Newark

11:15 A. M.

The Inner, the Middle and the External Ear  
Henry C. Barkhorn, M.D., Newark

11:30 A. M.

Involvement of the Nose and the Mouth  
Oram R. Kline, M.D., Camden

**GASTRO-ENTEROLOGY**JACOB L. MATHESHEIMER, M.D., Chairman  
HARRISON R. WESSON, M.D., Secretary

Viking Room, 13th Floor

10:00 A. M.

Some Problems in the Management of Cancer of the Rectum  
Homer I. Silvers, M.D., Chief of Colonic and Rectal Surgery, Atlantic City Hospital, Atlantic City  
Discussers: George N. J. Sommer, M.D., Trenton; Abraham L. Reich, M.D., Newark

10:30 A. M.

The Diagnosis of Gall-Bladder Disease  
Louis L. Perkel, M.D., Attending Gastro-Enterologist, Medical Center, Jersey City  
Discussers: S. Bernard Kaplan, M.D., Newark; Harrison R. Wesson, M.D., Montclair

11:00 A. M.

Stricture of the Rectum  
Frank C. Yeomans, M.D., Professor of Proctology, New York Polyclinic Medical School and Hospital, New York City  
Discussers: A. W. Martin Marino, M.D., Brooklyn; Julius Gerendasy, M.D., Elizabeth

11:30 A. M.

Liver Therapy (and B-Complex) in Cirrhosis of the Liver and Atrophic Gastritis  
Hyman I. Goldstein, M.D., Camden  
Discussers: Charles L. Brown, M.D., Philadelphia; Harold S. Davidson, M.D., Atlantic City

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**MEDICINE**CLARENCE W. WAX, M.D., Charman  
EDWARD C. KLEIN, JR., M.D., Secretary

Garden Room, Lounge Floor

10:00 A. M.

"Fact, Functional or Fake"  
James Arnold Brussel, Captain, Medical Corps, United States Army; Chief Neuropsychiatrist, Station Hospital, Fort Dix

10:30 A. M.

Spontaneous Subarachnoid Hemorrhage  
Bernard A. Hirschfield, M.D., Trenton  
Anthony S. Tornay M.D., Philadelphia, Pa.  
Joseph C. Yaskin, M.D., Philadelphia, Pa.

11:00 A. M.

Early Diuresis in Congestive Heart Failure  
Clarence L. Andrews, M.D., Atlantic City

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**OBSTETRICS AND GYNECOLOGY**HARRISON B. WILSON, M.D., Chairman  
ROBERT A. MACKENZIE, M.D., Secretary

Roberts Room—Chalfonte

10:00 A. M.

A Twenty-four-Hour Pregnancy Test  
John Huberman, M.D., Newark  
M. Jonas Colmer, M.D., Newark

10:15 A. M.

The Limitations of the Use of Forceps and Its Abuses  
J. Carlisle Brown, M.D., Atlantic City

10:30 A. M.

The Management of the Toxemias of Pregnancy  
Carl H. Ill, M.D., Newark

10:45 A. M.

Rupture of the Uterus—Its Causes and Treatment  
Robert R. White, M.D., East Orange

11:00 A. M.

The Treatment of Recurrent and Threatened Abortion  
William J. Carrington, M.D., Atlantic City

11:15 A. M.

Panel Discussion on papers presented, conducted by Arthur W. Bingham, M.D., Walter B. Mount, M.D., Samuel A. Cosgrove, M.D., and Thaddeus L. Montgomery, M.D. Questions and discussion from the floor will be encouraged.

1:00 P. M.

Luncheon—Gold Room, Chalfonte

A luncheon for the Maternal Welfare Committee Field Physicians and those doctors interested in obstetrics and gynecology. Meeting in charge of Arthur W. Bingham, M.D.

Luncheon Thesis:

The Management of the Infertile Pregnant Patient  
Thaddeus L. Montgomery, M.D., Philadelphia, Pa.

This luncheon is a transferred meeting of the Northern New Jersey Academy of Medicine Section on Obstetrics and Gynecology.

## PEDIATRICS

HARROLD A. MURRAY, M.D., Chairman  
MAURICE L. RIPPS, M.D., Secretary

Bakewell Room, 1st Floor

10:00 A. M.

Panel Discussion—The Acute Abdomen in Infancy  
Edward J. Donovan, M.D., New York City  
Edward W. Sprague, M.D., Newark  
Irvin E. Deibert, M.D., Camden

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## RADIOLOGY

NATHAN J. FURST, M.D., Chairman  
HARRY J. PERLBERG, M.D., Secretary

Tower Room, 13th Floor

10:00 A. M.

The Correlation of Roentgen Ray Diagnosis of Lesions of the Stomach and Duodenum with the Operative Findings

W. James Marquis, M.D., Newark  
Charles F. Baker, M.D., Newark

10:30 A. M.

Atypical Tumors of the Mediastinum  
Philip Santora, M.D., Newark  
Benjamin Copleman, M.D., Perth Amboy

11:00 A. M.

Osteomyelitis of Skull  
Raphael Pomeranz, M.D., Newark

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## SURGERY

WILLIAM W. COX, M.D., Chairman  
LORRIMER B. ARMSTRONG, M.D., Secretary

Benjamin West Room, 13th Floor

### PANEL DISCUSSION

10:00 A. M.

Wound Infections, Diagnosis and Treatment  
Irvin E. Deibert, M.D., Camden  
Discusser: C. Abbott Beling, M.D., Newark

10:25 A. M.

Surgery of the Diabetic  
Stuart Z. Hawkes, M.D., Newark  
Discusser: Alexander Ellis, M.D., Camden

10:50 A. M.

Abdominal Symptoms of Urological Origin in Children  
Meredith F. Campbell, M.D., New York City

11:10 A. M.

Shock, Diagnosis and Treatment  
Robert H. Hill, M.D., Newark  
Discusser: Carl Schoenau, M.D., Bloomfield  
Moving Picture Demonstration

11:35 A. M.

The Diagnosis and Treatment of Traumatic Epilepsy  
K. Winfield Ney, M.D., New York City  
Discusser: Carl Schoenau, M.D., Bloomfield



**SCIENTIFIC MOTION PICTURE THEATRE**

Pavillon, Lounge Floor

These films are shown through the courtesy of  
**Joseph P. Hackel, Medical Film Guild, New York, New York**

**Tuesday Morning, April 21, 1942**

9:00 A. M.

Otitis Media in Pediatrics  
 Murray B. Gordon, M.D., New York City  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

9:45 A. M.

A Clinic on Acute Mastoiditis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

10:25 A. M.

Colored Cinematography of the Epipharynx  
 S. Eugene Dalton, M.D., Atlantic City

10:45 A. M.

A Herniation of a Nucleus Pulposus, the Diagnosis  
 and Treatment by Laminectomy and Chip Fu-  
 sion  
 Henry Briggs, M.D., East Orange

**Tuesday Afternoon, April 21, 1942**

2:00 P. M.

A Clinic on Petrositis with Meningitis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

2:40 P. M.

Otoscopy in the Inflammations  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

3:20 P. M.

A Herniation of a Nucleus Pulposus, the Diagnosis  
 and Treatment by Laminectomy and Chip Fu-  
 sion  
 Henry Briggs, M.D., East Orange

4:00 P. M.

Physiology of Respiration; Pharmacology and Clin-  
 ical Uses of Coramine  
 Ciba Pharmaceutical Company, Summit

**Wednesday Morning, April 22, 1942**

9:00 A. M.

Colored Cinematography of the Epipharynx  
 S. Eugene Dalton, M.D., Atlantic City

9:20 A. M.

A Herniation of a Nucleus Pulposus, the Diagnosis  
 and Treatment by Laminectomy and Chip Fu-  
 sion  
 Henry Briggs, M.D., East Orange

10:00 A. M.

Otoscopy in the Inflammations  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

10:40 A. M.

A Clinic on Acute Mastoiditis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

11:20 A. M.

A Clinic on Petrositis with Meningitis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

**Wednesday Afternoon, April 22, 1942**

2:00 P. M.

Otitis Media in Pediatrics  
 Murray B. Gordon, M.D., New York City  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

2:45 P. M.

A Clinic on Acute Mastoiditis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

3:25 P. M.

A Clinic on Petrositis with Meningitis  
 Samuel J. Kopetzky, M.D., New York City  
 Ralph Almour, M.D., New York City

4:05 P. M.

Physiology of Respiration; Pharmacology and Clin-  
 ical Uses of Coramine  
 Ciba Pharmaceutical Company, Summit

## SCIENTIFIC EXHIBITS

Vernon Room, Lounge Floor

### ARRANGED BY THE SUBCOMMITTEE ON SCIENTIFIC EXHIBITS OF THE COMMITTEE ON ANNUAL MEETING

WILLIAM W. HERSOHN, M.D., Chairman, Atlantic City

#### Booth 1

Maternal Welfare of New Jersey  
The Committee on Maternal Welfare of The Medical Society of New Jersey

#### Booth 2

New Jersey Formulary Preparations  
Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association

#### Booth 3

Surgical Treatment of Cancer of the Rectum and Sigmoid with Perineal Anus  
W. Wayne Babcock, M.D., and Harry E. Bacon, M.D., Temple University School of Medicine, Philadelphia, Pa.

#### Booth 4

Evaluation of Heart Size Measurements  
Robert M. Daley, M.D., Richard S. Gubner, M.D., and Harry E. Ungerleider, M.D., Equitable Life Assurance Society of the United States, New York, N. Y.

#### Booth 5

Bronchiogenic Carcinoma—An Analysis of Fifty-six Histologically Proven Cases  
Thomas J. White, M.D., Samuel Cohen, M.D., and A. M. Gnassi, M.D., Jersey City Medical Center, Jersey City, N. J.

#### Booth 6

Growth Dyscrasias—Clinical and Roentgenological Survey  
Rita S. Finkler, M.D., Nathan J. Furst, M.D., and George Cohn, M.D., Newark Beth Israel Hospital, Newark, N. J.

#### Booth 7

The Public Health Aspects of Trichinosis  
W. H. Wright, M.D., National Institute of Health, Division of Zoology, Bethesda, Maryland

#### Booth 8

Obesity Treated with Amphetamine (Benzedrine) Sulfate and Thyroid  
S. William Kalb, M.D., New York Post-Graduate Medical School and Hospital, Newark, N. J.

#### Booth 9

Osteomyelitis of the Skull—A Radiologic Study  
Raphael Pomeranz, M.D., Newark City Hospital and Newark Beth Israel Hospital, Newark, N. J.

#### Booth 10

A Twenty-Four Hour Pregnancy Test  
Robert J. Frank, Technician; John Huberman, M.D., and M. Jonas Colmer, M.D., Newark Beth Israel Hospital (Roche-Organon, Inc. Grant), Newark, N. J.

#### Booth 11

Traumatic Surgery and Plastic Repair—Repair of Traumatic Injuries  
Morton I. Berson, M.D., Pan-American Clinic, New York, N. Y.

#### Booth 12

Selective Sterilization for Human Betterment  
Sterilization League of New Jersey, Princeton, N. J.

#### Booth 13

Carcinoma of the Colon and Rectum  
Thomas A. Shallow, M.D., Kenneth E. Fry, M.D., and Joseph Norton, M.D., Jefferson Hospital, Philadelphia, Pa.

#### Booth 14

Otitic Complications in Infectious Diseases  
Samuel J. Kopetsky, M.D., Ralph Almour, M.D., and Murray Godon, M.D., New York Polyclinic Hospital, Beth Israel Hospital and Kingston Hospital, New York, N. Y.

#### Booth 15

Fracture Appliance Unit for Fracture of Jaws, Facial Bones and Nose  
Harry L. Bisnoff, M.D., Jamaica, L. I., N. Y.

#### Booth 16

Cystoscopic Photography  
Lowrain E. McCrea, M.D., Temple University Medical School, Philadelphia, Pa.

#### Booth 17

Rheumatic Fever  
Metropolitan Life Insurance Company, New York, N. Y.

#### Booth 18

Child Welfare in Essex County  
Child Welfare Committee of the Essex County Medical Society, Newark, N. J.

#### Booth 19

Oxygen in Blood—Clinical Significance and Measurement

W. G. Exton, M.D., A. R. Rose, Ph.D., F. Schattner, and S. Korman, Laboratory and Longevity Service, Prudential Insurance Company of America, Newark, N. J.

#### Booth 20

New Jersey League for Planned Parenthood, Newark, N. J.

#### Booth 21

Pathology of Arthritis  
Samuel A. Goldberg, M.D., Presbyterian Hospital, Newark, N. J.

#### Booth 22

A. Pathology of Common Cardiac Disease with Representative Associated Electrocardiograms

B. Oral Manifestations of Occupational Disease  
N. J. Association of Industrial Physicians and Surgeons

#### Booth 23

Procurement and Assignment Service  
Committee on Medical Preparedness of The Medical Society of New Jersey

#### Booth 24

Ruptured Nucleus Pulposus—Chip Fusion of the Low Back Following Exploration of the Spinal Canal

Henry Briggs, M.D., New Jersey Orthopaedic Hospital, East Orange, N. J.

## TECHNICAL EXHIBITS

### Parlor, Lounge Floor

Technical Exhibitors will show you what is available under their restrictions this year and this will be of especial interest to you. Be sure to register at their booths when you visit the Annual Meeting and carefully look over their material so that you will know what you can get in these strenuous times. There will, no doubt, be many new things in which you will be interested. These exhibitors have in the most part been with us each year and you will find personal friends who have served you faithfully in the past and will continue to do so for the duration. You will need their help and you can help them by this show of interest.

**Booth 1—Sharp & Dohme, Philadelphia, Pa.,** will have their modern display featuring "Lyovac" Normal Human Plasma, other "Lyovac" biologicals and biological specialties. There will also be on display a group of pharmaceutical specialties, such as the new Liquid "Digitol" and Tablets "Digitol" which are clinically standardized in humans, "Delvinal" Sodium, "Propadrine" Hydrochloride products, "Rabellon", "Riona", "Depropanex", and "Prohexinol". Capable well-informed representatives will be on hand to welcome all visitors and furnish information on Sharp & Dohme products.

**Booth 2—Burroughs Wellcome & Co. U. S. A., Inc., New York,** presents a selected group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

**Booth 3—The C. V. Mosby Company, St. Louis, Mo.,** extends to convention visitors a cordial invitation to visit Booth 3. Among the new books to be displayed are Kilduffe-DeBakey "The Blood Bank and the Technique and Therapeutics of Transfusions", Dieckmann "The Toxemias of Pregnancy", Blair "Cancer of the Face and Mouth", Thewlis "The Care of the Aged", Willius "Mayo Cardiac Clinics", Top "Handbook of Communicable Diseases", Tassman "Eye Manifestations of Internal Diseases" and Alexander "Synopsis of Allergy". New editions will include Crossen and Crossen "Diseases of Women", Porter and Carter "Management of the Sick Infant and Child", Marriott-Jeans "Infant Nu-

trition", Herrmann "Synopsis of Diseases of the Heart and Arteries", and Dodson "Synopsis of "Genitourinary Diseases".

**Booth 4—Holland-Rantos Company, Inc., New York, N. Y.** Modern contraceptive technique will be graphically illustrated with a motion picture, and all the various contraceptive materials including both the *Koromex* and *Hyva diaphragms*, *Koromex jelly* and *H-R Emulsion cream*, together with the most complete line of contraceptive specialties, will be demonstrated at the booth of the Holland-Rantos Company. Be sure to call for samples and literature.

Displayed, also, will be the new *Rantex Surgical Masks and Caps*, now being used by hospitals all over the country. They represent an outstanding development.

**Booth 5—Smith, Kline and French Laboratories, Philadelphia, Pa.—**We welcome this opportunity to again display our products, including *Benzedrine Inhaler*, *Benzedrine Sulfate Tablets*, *Benzedrine Solution* and *Pentnucleotide*, to the members of the Society. Our representatives will be only too glad to discuss the products exhibited and to answer any questions that may arise concerning them.

**Booth 6—The Mennen Company, Newark, N. J.,** will exhibit their two baby products—*Antiseptic Oil* and *Antiseptic Borated Powder*. The *Antiseptic Oil* is now being used routinely by more than 90 per



cent of the hospitals that are important in maternity work. Be sure to register at the Mennen exhibit and receive your kit containing demonstration sizes of their shaving and after-shave products; also, for the lucky number prize drawing to be held at the close of the Convention for De Luxe Leather Toilet Kits.

**Booths 7 and 8—Mead Johnson & Company,** Evansville, Ind. "Servamus Fidem" means "We Are Keeping the Faith." Almost every physician thinks of Mead Johnson & Company as the maker of *Dextri-Maltose*, *Pabulum*, *Oleum Percomorphum*, and other infant diet materials. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booths 7 and 8 will be time well spent.

**Booth 9—C. B. Fleet Co., Inc.,** Lynchburg, Va. *Phospho-Soda (Fleet)* has been an ethical product over half a century. It is a highly concentrated, purified, aqueous solution of the two U. S. P. phosphates in stable form. It is non-toxic, rapid, but mild in action, without irritation of the gastric or intestinal mucosa. It is indicated in hepatic and gall-bladder dysfunctions, and when a thorough eliminating and cleansing action is desired on the upper and lower gut.

**Booth 10—The Alkalol Company,** Taunton, Mass., producers of *Alkalol and Irrigol*, was established in 1896, and has always adhered strictly to ethical advertising. *Alkalol* is a scientifically balanced solution for all mucus membranes and irritated tissues. *Irrigol* is a cleansing powder which makes a valuable solution for vaginal douching, colonic irrigations and rectal enemas.

**Booth 11—The Sun-Ray Co. (Div. Kemp Brothers Packing Co.),** Frankfort, Ind., producers of *Kemp's Sun-Ray Brand Tomato Juice*. The natural, pasteurized juice of a special strain of Indiana tomatoes, sun-ripened on the vines and U. S. Government graded. The whole, carefully cored tomato is converted into juice by Kemp's patented process No. 1746657, which utilizes all the tender solids for high retention of vitamins A, B-1 and C, insures non-separating color and never-thin-or-watery consistency. Samples served at booth. Representative in charge: Seggerman Nixon Corporation, 111 Eighth Avenue, N. Y. C., Frederick J. Nixon.

**Booth 12—Ciba Pharmaceutical Products, Inc.,** Summit, N. J. Physicians are cordially invited to visit the Ciba booth, No. 12, where representatives of the firm will be glad to answer questions about and discuss the well-known Ciba specialties, among which are *Digifoline*, *Dial*, *Lipiodine*, *Nupercaine* and *Vioform*. Your call will be welcomed.

**Booth 13—The Borden Company,** New York, N. Y. Up-to-date information about Borden's scientifically designed infant foods at Booth No. 13. *Biolac*, a liquid modified milk, facilitates the preparation of formulas which fully satisfy all nutritional requirements of early infancy except vita-

min C. *New Improved Dryco* (now spray dried instead of roller dried) has increased potencies of vitamins A and D and quicker solubility. It retains the same high-protein low-fat composition of original Dryco and offers the same unique formula flexibility. *Mull-Soy*, an emulsified food for infants allergic to milk, is exceptionally palatable, readily digestible, and easy to prepare for feeding. It is a liquid preparation for soy-bean flour, soy bean oil, water, and added carbohydrate and mineral salts. Other infant foods of special merit include *Beta-Lactose*, the improved milk sugar; *Klim*, *Merrell-Soule Powdered Milks*, and *Borden's Silver Cow Irradiated Evaporated Milk*.

**Booth 14—The Liebel-Flarsheim Company,** Cincinnati, Ohio, will exhibit the *L-F Short and Ultra-Short Wave Generators* \* \* \* as well as the famous *Bovie Electrosurgical Units* at Booth No. 14. In addition, other newly developed and interesting physical therapy apparatus and accessories will be shown.

It will be a pleasure to demonstrate this modern equipment to you and the time spent at Liebel-Flarsheim Booth No. 14 will prove well worth while.

**Booth 15—The Coca-Cola Company,** Atlanta, Ga.—*Coca-Cola* will be served at Booth 15 to the Delegates and Members of The Medical Society of New Jersey and their guests and friends with the compliments of The Coca-Cola Company.

**Booth 16—Endocrine Food Company,** Union City, N. J. Of current interest to the physician will be our exhibit of *Estrogens, Stilbestrol, and Vitamin Products* of pharmaceutical potencies. All products conform in every respect to the U. S. Pharmacopoeia, State and Federal Food and Drug standards and recommendations. We welcome the opportunity to exhibit with you.

**Booth 17—The Denver Chemical Mfg. Company,** New York, N. Y. In Booth No. 17 will be exhibited *Antiphlogistine*, the medicated dressing employed by practitioners throughout the world in treating inflammations and congestions. Also *Galatest*, the dry reagent for the instantaneous detection of urine sugar.

**Booth 18—Doho Chemical Corporation,** New York, N. Y. *The Auralgan Exhibit* consists of a model of the human auricle four feet high together with a series of twenty-four three-dimensional ear drums, modelled under the supervision of outstanding otologists. Each of these drums depict a different pathologic condition based upon actual case observation and prepared, insofar as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

**Booth 19—Davies, Rose & Company, Limited,** Boston, Mass., find pleasure in greeting the members of The Medical Society of New Jersey and their friends. A cordial welcome is extended to those who may find it convenient to visit the firm's Booth No. 19, where an opportunity will be given

to discuss each of its various products. The firm will be represented at the meeting by Mr. F. L. Moulton, well known to many of the medical practitioners of New Jersey.

**Booth 20—Gerber Products Company, Fremont, Mich.**—*Gerber Baby Foods* are growing so fast we will welcome your call at our booth so we may show you the newest arrivals. The literature is revised frequently, and we would like to have you look it over. The professional reference cards are made entirely for your convenience, and they are brought up to date after each packing season.

**Booth 21—E. R. Squibb & Sons, New York, N. Y.**—A number of new and interesting *Vitamin, Glandular, Biological and Chemotherapeutic* specialties will be featured in the Squibb Exhibit in Booth No. 21. Well-informed Squibb representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

**Booth 22—"The 'Junket' Folks," Chr. Hansen's Laboratory, Inc., Little Falls, N. Y.,** will exhibit enlarged photos to illustrate graphically the action of the rennet enzyme in forming softer, finer milk curds. Display of "*Junket*" *Brand Food Products*. Free literature describes dietary uses of rennet-custards in infant, child, convalescent, or post-operative feeding. Well-informed attendant on duty at all times.

**Booth 23—The Chas. H. Phillips Chemical Co., New York, N. Y.**—"Phillips' Milk of Magnesia" (liquid and tablet forms) and "*Italey's M-O*"—standards in the field of alkaline laxative therapy—will feature the exhibit of The Chas. H. Phillips Chemical Co. Physicians are invited to visit Booth No. 23 to receive samples of these famous products.

**Booths 24 and 25—Pet Milk Sales Corporation, St. Louis, Mo.**—An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in Booths Nos. 24 and 25. This exhibit offers an opportunity to obtain information about the production of *Irradiated Pet Milk* and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk Booth.

**Booth 26—White Laboratories, Inc., Newark, N. J.**—*White's Cod Liver Oil Concentrate* will be presented in Booth No. 26 for your consideration. Here you may obtain complete information concerning the entire field of cod liver oil concentration, with clinical data substantiating the efficacy of White's Liquid, Tablet and Capsule Concentrate. Qualified representatives and descriptive literature, including reprints and excerpts from medical literature, will further direct attention to the contribution of White Laboratories in the vitamin A and D field. White Laboratories holds an established place as one of the world's largest manufacturers of cod-liver oil concentrates. All physicians are cordially invited to visit the booth.

**Booth 27—Eli Lilly and Company, Indianapolis, Ind.**—The *Lilly* exhibit is evidence of the interest of Eli Lilly and Company in The Medical Society of New Jersey. Lilly products both old and new will be on display and Lilly representatives will be present to serve physicians in every possible way.

**Booth 28—Philip Morris & Co., Ltd., Inc., New York, N. Y.**—Philip Morris & Company will demonstrate the method by which it was found that *Philip Morris Cigarettes*, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

**Booth 29—Reed & Carnrick, Jersey City, N. J.,** steadfastly ethical since 1860, have striven to go forward step by step with the advance of scientific medicine. In addition to *Estrogenic Hormones R & C*, which is triple assayed, economical and packaged in four important strengths (including Tablets Estrogenic Hormones R & C for oral administration), they respectfully call to your attention their growing line of ampuls, important among which are *Thiamin Hydrochloride* (Vitamin B<sub>1</sub>, R & C), *Purified Solution of Liver, B<sub>1</sub>, Liver and Iron, and Calcium Gluconate*.

**Booth 30—Schering Corporation, Bloomfield, N. J.**—*Oreton*, the most potent androgenic hormone known to medicine; *Oreton-M Tablets* for orally effective male hormone therapy; *Pranone*, the orally effective corpus luteum preparation—in fact, all the highly advanced Schering hormones are on display at the Schering exhibit, which is practically a survey of recent endocrine progress. In addition, there are some other particularly interesting products such as *Sulamyd* (Sulfacetimide) for the treatment of urinary tract infections, and *Sulfadiazine-Schering*, most efficient sulfonamide for pneumonia. Members of the Medical Research Division will be present and welcome discussion of problems. Representatives attending: Dr. Max Gilbert, Dr. Marvin Weinberg, Mr. C. Silirie.

**Booth 31—Cameron Surgical Specialty Co., Chicago, Ill.** See the new *Cameron Omniangle Flexible Gastroscope*, *Binocular Prism Loupe*, *Color-Flash Clinical Camera*, the *Mirrolite* and latest developments in electrically lighted Diagnostic and Operating instruments for all parts of the body. Of special interest are the new *Spark Gap & Tube Electro-Surgical Units* for cutting, coagulating, desiccation, fulguration and ultra-violet therapy in all sizes from the office model *Cauteradio* to the *Combination Major Surgical Hospital Unit* with an abundance of power for the most radical work.

**Booth 32—Parke-Davis & Co., Detroit, Mich.** Featured in the Parke-Davis Exhibit will be the sex hormones, *Theclin* and *Theclol*; antisyphilitic agents, such as *Mapharsen* and *Thio-Bismol*; posterior lobe preparations, including *Pituitrin*, *Pitocin*

and *Pitressin*; and various *Adrenalin Chloride Preparations*.

**Booth 33—Hanovia Chemical and Manufacturing Company, Newark, N. J.** Hanovia will display a complete line of the new self-lighting ultraviolet quartz lamps. Don't fail to witness a demonstration of the new air-cooled *Kromayer Lamp* for local application. *Sollux Radiant Heat Lamps*, *Short Wave Diathermy* and *Safe-T-Aire* germicidal lamps will also be displayed. Courteous and competent representatives will be on hand to serve you.

**Booth 34—National Casualty Company, Jersey City, N. J.**—The State Medical Society's endorsed *Physician's Special Policy of Accident and Health Insurance* continues to be the most widely endorsed accident and health policy for physicians in the metropolitan area. Individual accident and health policies are issued to eligible physicians and surgeons up to the age limit of 65, from \$100.00 monthly to \$300.00 monthly benefits, with or without accidental death indemnity and hospital residence expense and nurse's service. For the literature and information regarding this policy, stop at Booth No. 34 in charge of *E. & W. Blanksteen*, 76 Montgomery Street, Jersey City, N. J., who are the Society's authorized accident and health insurance representatives.

**Booth 35—Faulhaber & Heard, Inc., Newark, N. J.**—Any member who desires information in connection with *professional liability protection*, a feature of membership, can obtain full particulars at Booth No. 35, maintained by Faulhaber & Heard, Inc., the Official Broker of The Medical Society of New Jersey. Ninety per cent of the members have taken advantage of this contract. This is evidence of the benefits derived by having their protection in the company that has served the Medical Society since 1921. Physicians subject to military service are advised to call at this booth for particulars if any adjustment is to be made in their professional liability contract.

**Booth 36—Picker X-Ray Corporation, New York, N. Y.**—Visitors to the Picker X-Ray Corporation's booth will have an opportunity of seeing the well-known *Picker-Waite "Century"*. This diagnostic unit provides for radiography and fluoroscopy in all positions from the vertical to the Trendelenberg. The table may be either hand or motor oper-

ated, and the table has as optional equipment a two-position spot film attachment for instantaneous radiography during fluoroscopy. There will also be on display a number of newly developed x-ray accessories and diagnostic opaque chemicals.

**Booth 37—Lederle Laboratories, Inc., New York, N. Y.**, will feature "*Cerevim*", their pre-cooked cereal product, together with a selection of leading medical products, in Booth No. 37. In the medical displays, *Hay Fever products*; *Tuberculin Patch Test*; *Tetanus Toxoid* and the complete line of B Complex vitamins including *Vi-Ferrin* (a preparation of ferrous sulfate and B Complex) introducing Lederle's new *Vitamin B Tablets*. Lederle staff attendants will be on hand to answer questions and to give out literature and samples covering all featured products.

**Booths 38 and 39—John Wyeth & Brother, Inc., Philadelphia, Pa.**, have made many worthwhile contributions to medicine during their eighty-two years. Among those of recent years are *Amphojel* (Wyeth's Aluminum Hydroxide Gel) for the treatment of peptic ulcer; *Silver Picrate* for trichomonas vaginitis, *Bepron*, a whole unfractionated liver with iron for nutritional anemias, and *B-Plex*, an elixir of brewer's yeast which supplies all the Vitamin B group. Be sure to call at the Wyeth booth, spaces 38 and 39, and obtain free the new Wyeth *Hemo-Guide*, an aid in the differential diagnosis of anemia and the interpretation of laboratory data.

**Booth 40—Petrogalar Laboratories, Inc., Chicago, Ill.**, offers, in addition to samples of the Five Types of *Petrogalar*, an interesting selection of descriptive literature and anatomical charts. Ask the Petrogalar representative, Mr. D. S. Vervoort, to show you the *Habit Time* booklet. It is a welcome aid for teaching bowel regularity to your patients.

**Booth 41—General Electric X-Ray Corp., Chicago, Ill.**—Factory-trained representatives are always ready to give immediate service or help to New Jersey users of *x-ray and electro-medical equipment*. They want to help every user to obtain the maximum in satisfactory performance of his equipment. In New Jersey, a manager, four salesmen and two servicemen work from the G-E branch office at 965 Broad Street, Newark. They are as easy to reach as your telephone.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

April, 1942

No. 4

THE gap between proven knowledge and effective action based on that knowledge, is nowhere more glaring than in our fumbling efforts at control of the most common of the infectious diseases.

We know that the time lost from the common cold would build hundreds of the planes we now need so much. Yet, the simple prophylactic measure of isolating all those with colds in early stages is applied routinely to a few school children only.

This failure to co-ordinate knowledge and action is also all too common in our efforts to control and eradicate tuberculosis.

### TUBERCULOSIS IS FOUND WHEN LOOKED FOR

That tuberculosis can be found and is most easily cured in the stage before symptoms appear is an axiom that has grown trite with repetition, yet the great majority of people fail to translate this into the action which will safeguard themselves and their families from this disease.

But what are the facts? In four years the deaths from tuberculosis surpass the number of those killed in all the wars the United States has ever fought. If the losses of one year from tuberculosis could be attributed to enemy action, the nation would be shocked with grief and vow vengeance at any cost. Yet, the slow undramatic dribbling away of lives goes on, day by day, though proof has been added to proof that this can be stopped.

For an example, take a look at our colleges and universities. Into their doors every Fall go hundreds of thousands of American youth, those favored ones of earth from whose ranks will come most of the trained men and women of our society. Yet, tuberculosis has already laid its hand upon many of these. During 1939-40, 637 cases of tuberculosis were found in 248 of these institutions with a total enrollment of 500,000 students, because it was looked for. Most of these infected students can be saved for useful, productive lives with a minimum of time lost.

What is the story where the college authorities report that no search is made? Only 35 cases appeared in 227 institutions among 200,000 students during the same period, is the answer. But is that

the whole story? No, for back of those 35 cases many more stand in shadowed ranks, already touched by the destroyer. It is easy to prove that tuberculosis is there—a tuberculin test, followed by an X-ray of positive reactors is the magic wand that will bring to light the hidden lesions. But when they are not found early we know the story too. Most of them will progress to the stage where treatment is to be reckoned in years, and complete cure is the exception.

The illustration here shown is based on the 1939-40 report of the Tuberculosis Committee of the American Student Health Association which was compiled from data received in response to a questionnaire which they sent to colleges and universities throughout the country. The 1940-41 report of the Committee changes it but little.

And what of the 402 institutions whose administrators did not even reply to the questionnaire? We can only surmise that they, too, have failed to translate the thing they know into the thing they do. Some of them, perhaps, are even unaware that tuberculosis is now, as it has always been, a foe of youth.

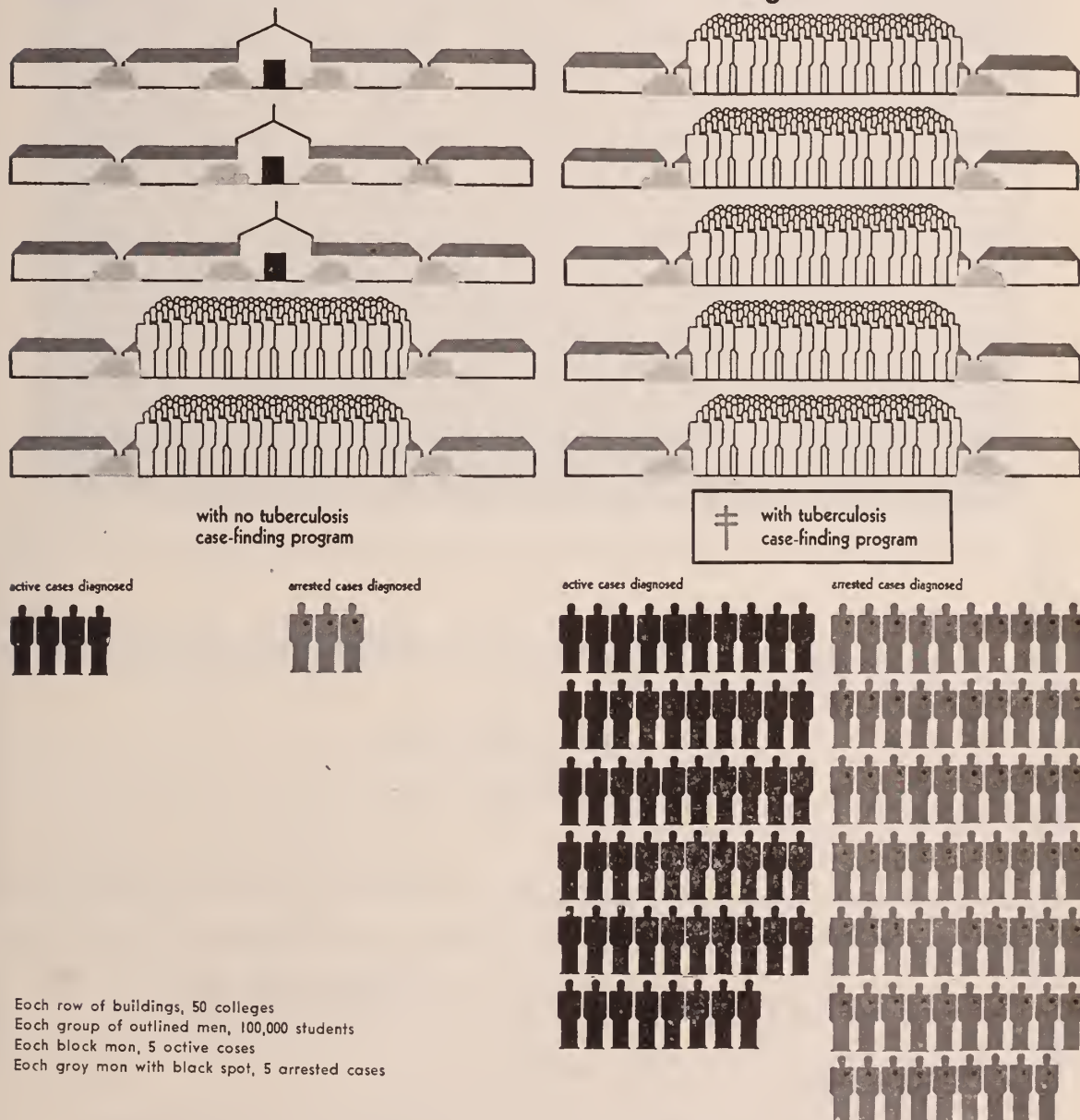
Yet, it is to the pursuit of knowledge that all these institutions are dedicated, and it was many years ago that Ralph Waldo Emerson said, "Education is not pouring knowledge into minds; it is not erudition. A person is not truly educated unless knowledge influences his *doing* as well as his *thinking*. Insofar as learning alters and directs *behavior* it is education."

In this respect, unfortunately, educators follow but the common path. In the trade union, the insurance office and the department store, in the hospitals and the homes for the aged, wherever men and women are gathered together, tuberculosis may be found when looked for. No class is exempt, no land is free from it—it is an enemy

power we know how to conquer, but the war is prolonged by "too little and too late."

*Based on reports of the Tuberculosis Committee of the American Student Health Association, Charles E. Lyght, M.D., Chairman, and published in the Journal-Lancet.*

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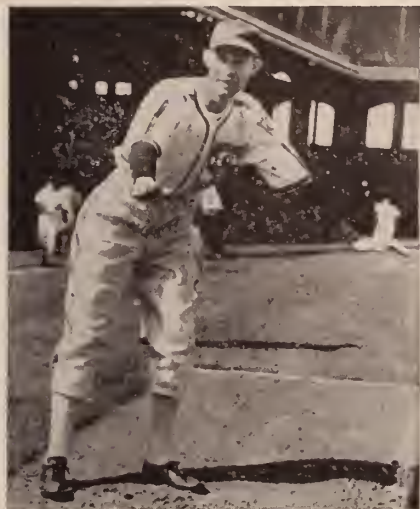
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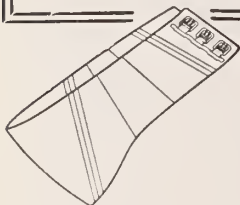
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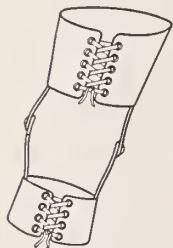
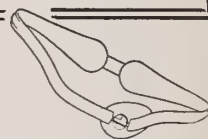
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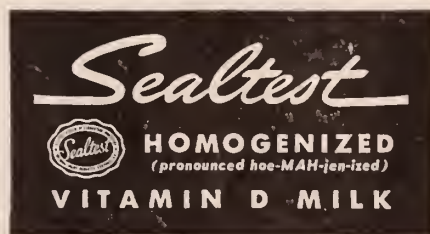
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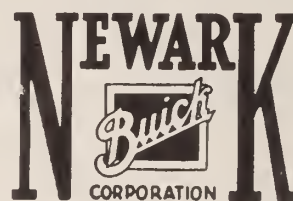
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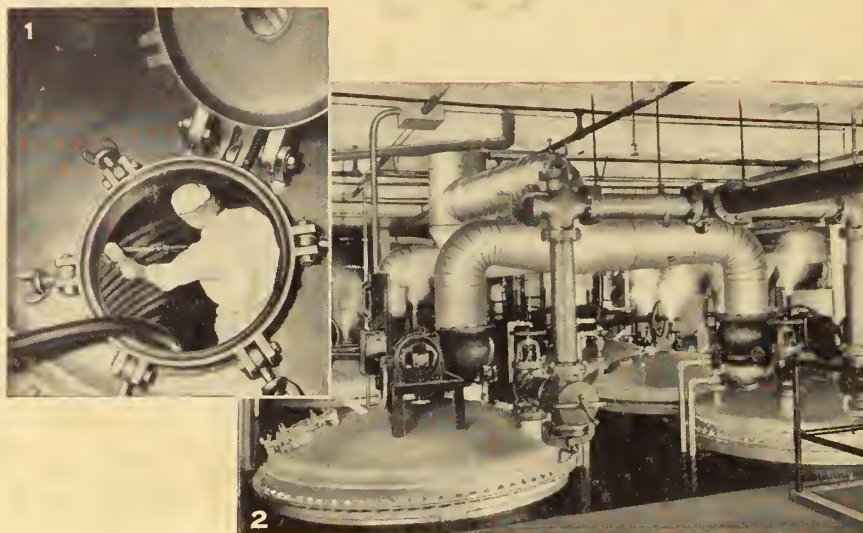
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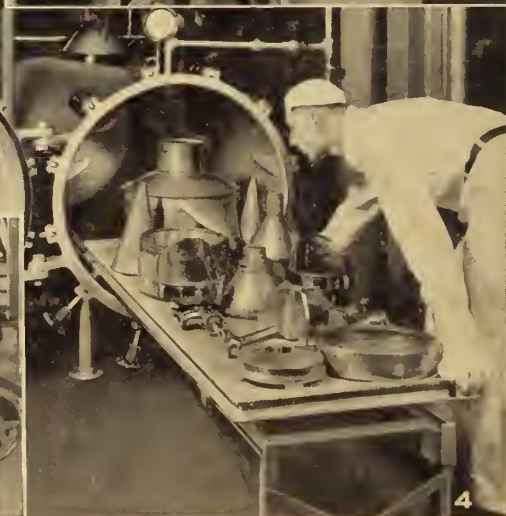
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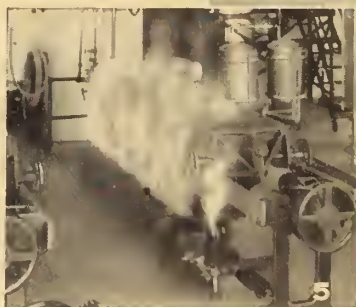
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# THE JOURNAL

OF

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### CONTENTS—Page

#### EDITORIALS—

HISTORY REPEATS ITSELF ..	249
LOOKING FORWARD .....	250
RESEARCH .....	251

#### THE WAR—

Appointments in the Army of the United States (Medical Department) .....	252
Appointments in the Navy Open to Medical Students .....	253
Appointments in the Naval Reserve Open to Medical and Dental Students .....	254
Appointments in the Naval Reserve Open to Medical Doctors .....	254
Emergency Medical Service Report .....	255
Temporary Hospitalization and Medical Care—Necessitated by Enemy Action to Civilians .....	257
Drug Monopoly Seen as Threat to Control of Malaria .....	258
Blood Collections for Army and Navy .....	259
Medical Preparedness in New Jersey .....	259
Shortcomings in Campaign for Physical Fitness .....	260
Books for Men in Service .....	260
Aviation Medicine .....	260
School Bus Ambulances .....	260

#### ORIGINAL ARTICLES—

MODERN TREATMENT OF URINARY TRACT INFECTIONS—Mortimer Reich, M.D., Newark, N. J. ....	261
RECOGNITION AND MANAGEMENT OF CARDIAC NEUROSIS—Joseph B. Wolffe, M.D., Philadelphia, Pa. ....	266
WHEN ARE DUODENAL AND GASTRIC ULCERS AND GALL-BLADDER DISEASE MEDICAL AND WHEN ARE THEY SURGICAL?—Manfred Kraemer, M.D., Newark, N. J. ....	270
DESCENT AND PROLAPSE OF THE UTERUS AND VAGINA—Arthur J. Walscheid, M.D., Union City, N. J. ....	274

THE CESAREAN OPERATION AND THE NEW JERSEY MATERNAL WELFARE REPORT. Maternal Welfare Article No. 69—Robert A. MacKenzie, M.D., F.A.C.S., Asbury Park, N. J. ....	280
A LESSON FROM A DEATH CERTIFICATE—No. 40 .....	284

#### RESEARCH DEPARTMENT—

PATHOLOGICAL CHANGES IN THE URINARY TRACT FOLLOWING EXCESSIVELY LARGE DOSES OF RIBOFLAVIN—William Antopol, M.D., Newark, N. J. ....	285
---	-----

#### STATE ACTIVITIES—

The 176th Annual Meeting .....	288
Scientific Exhibits Award .....	289
Infant Resuscitation .....	290
With New Jersey Medical Authors .....	291
Supplementary List of Members No. 1 .....	292

#### OBITUARIES

293

#### THE BULLETIN BOARD

294

#### COUNTY SOCIETY REPORTS—

Atlantic, Burlington, Camden .....	295
Essex .....	296
Gloucester, Hudson .....	297
Middlesex, Morris .....	298
Passaic, Salem .....	299
Sussex, Union, Summit Medical Society .....	300

#### WOMAN'S AUXILIARY—

Coming Events .....	301
Annual State Meeting .....	301
Salute to Mrs. Allman .....	302
Why Not an Auxiliary Defense Project? .....	302
"M" Is for Mercer and Middlesex Counties .....	303

#### THE BOOK SHELF

304

#### TUBERCULOSIS ABSTRACTS

309

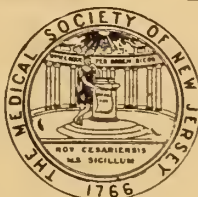
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Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

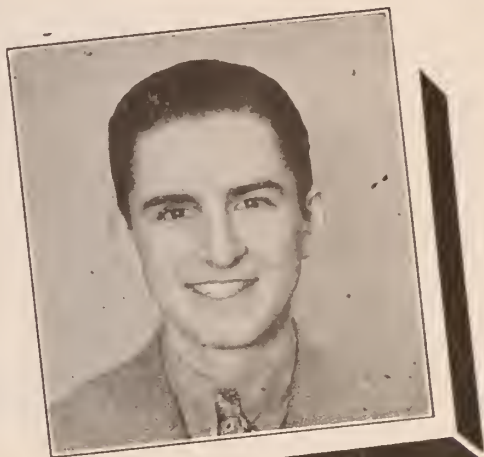
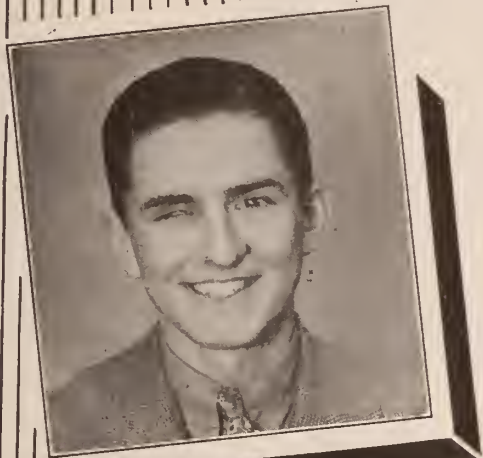


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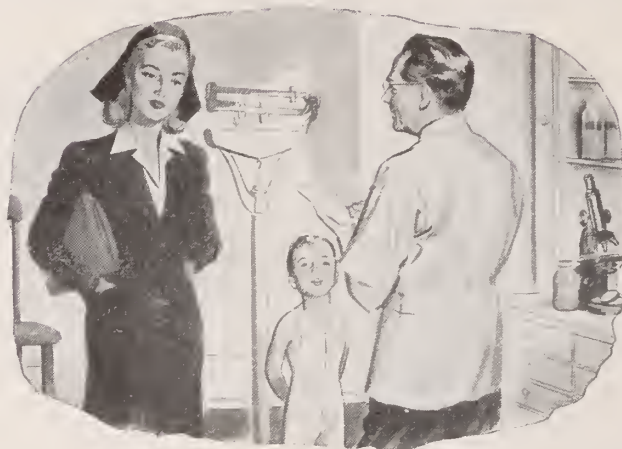
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1934. U. S. Pub. Health Reports 49, 754.  
1937. U. S. Dept. Agr. Misc. Publ. No. 275.  
1938. Food Research 3, 549.  
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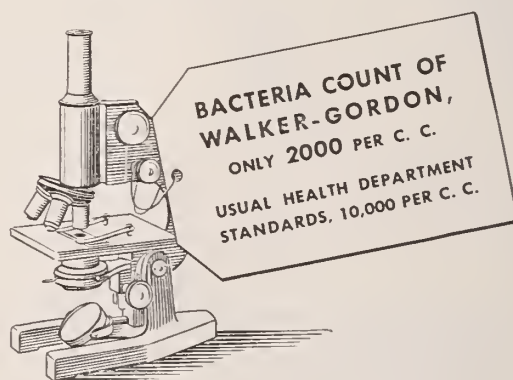
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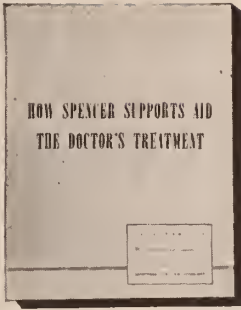
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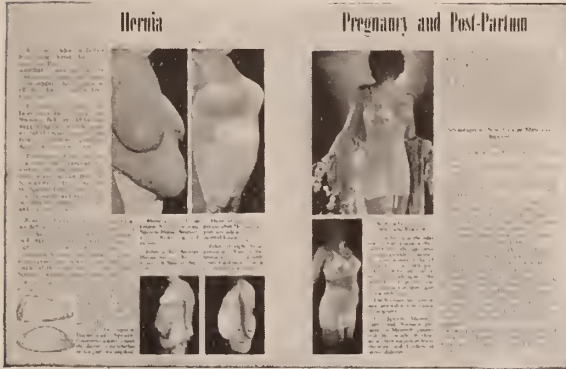




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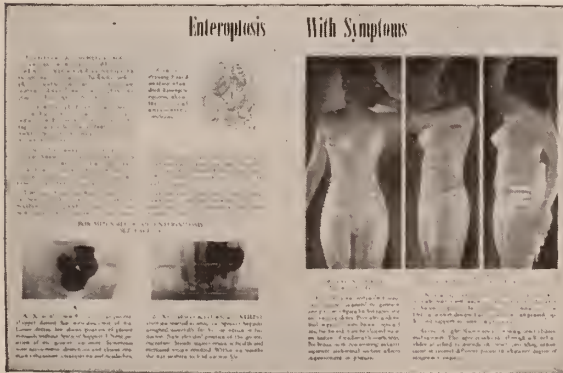
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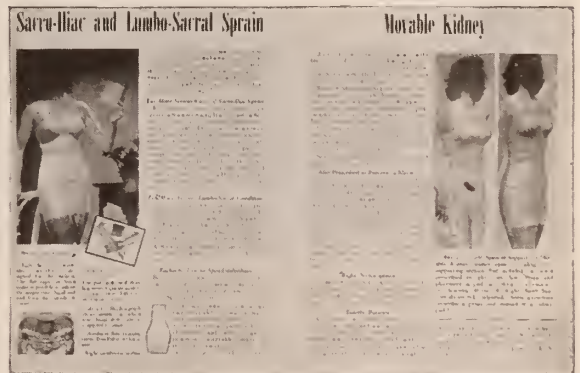
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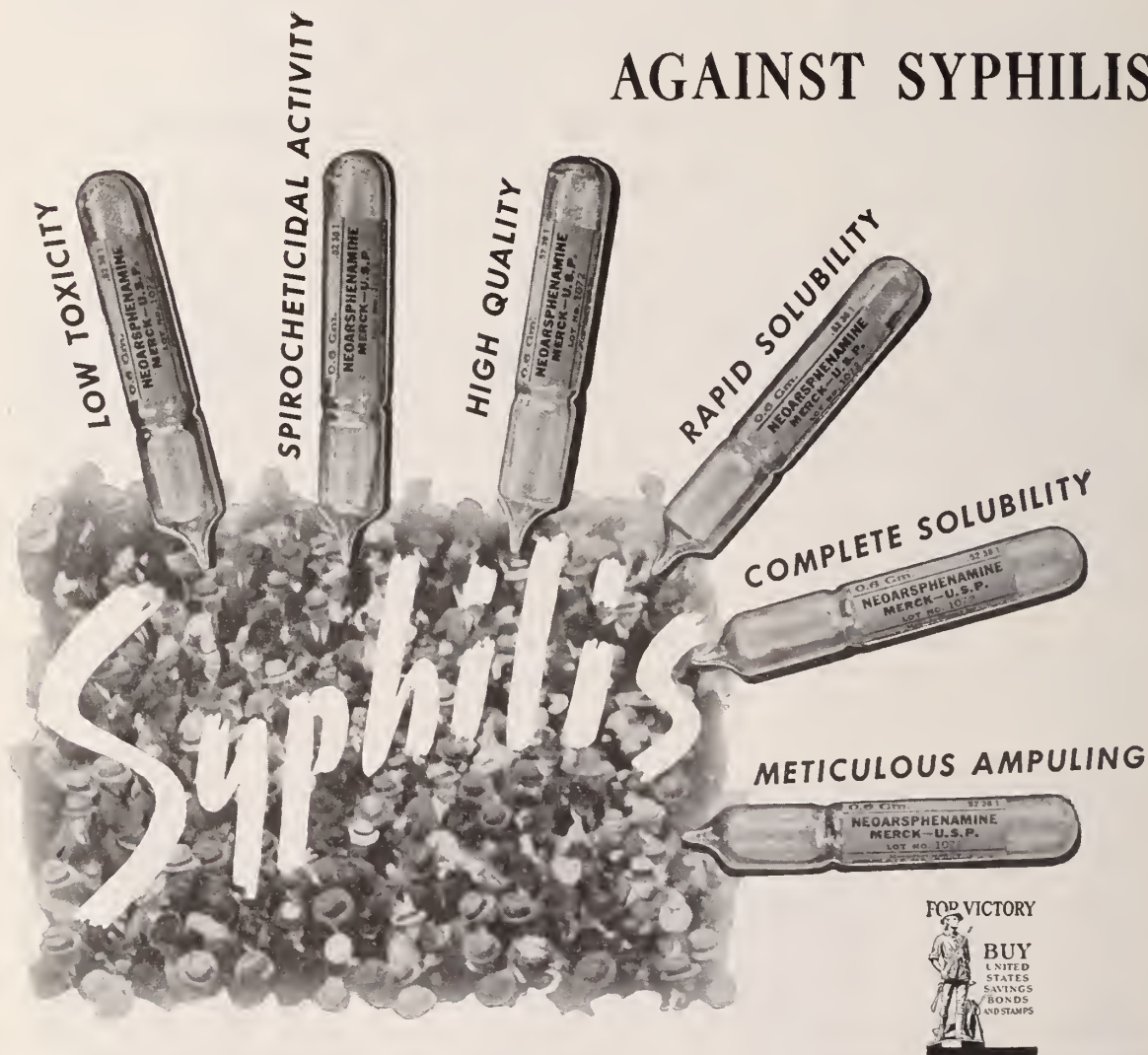
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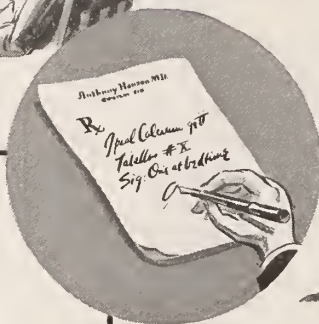
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\* J. A. M. A., 93:1110 — October 12, 1929

Brückner, H—Die Biochemie des Tabaks, 1936

\*\* The Military Surgeon, Vol. 89, No. 1, p. 7,  
July, 1941

**SEND FOR REPRINT** of an important contribution to medical literature—"The Cigarette, The Soldier, and The Physician," *The Military Surgeon*, July, 1941. This significant analysis reveals many new angles about smoking that should be valuable to you when modifying patients' smoking without disturbing their smoking enjoyment. Write to Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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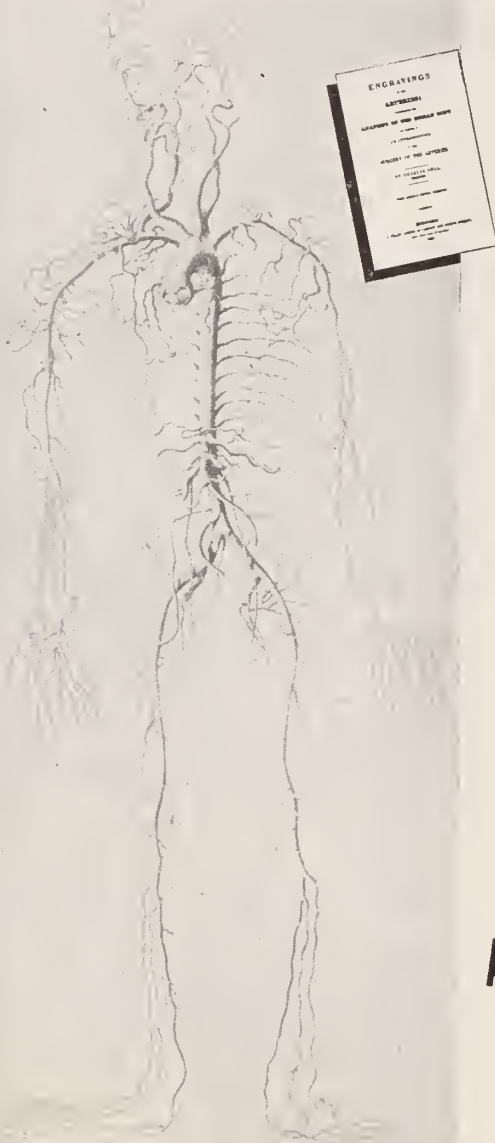
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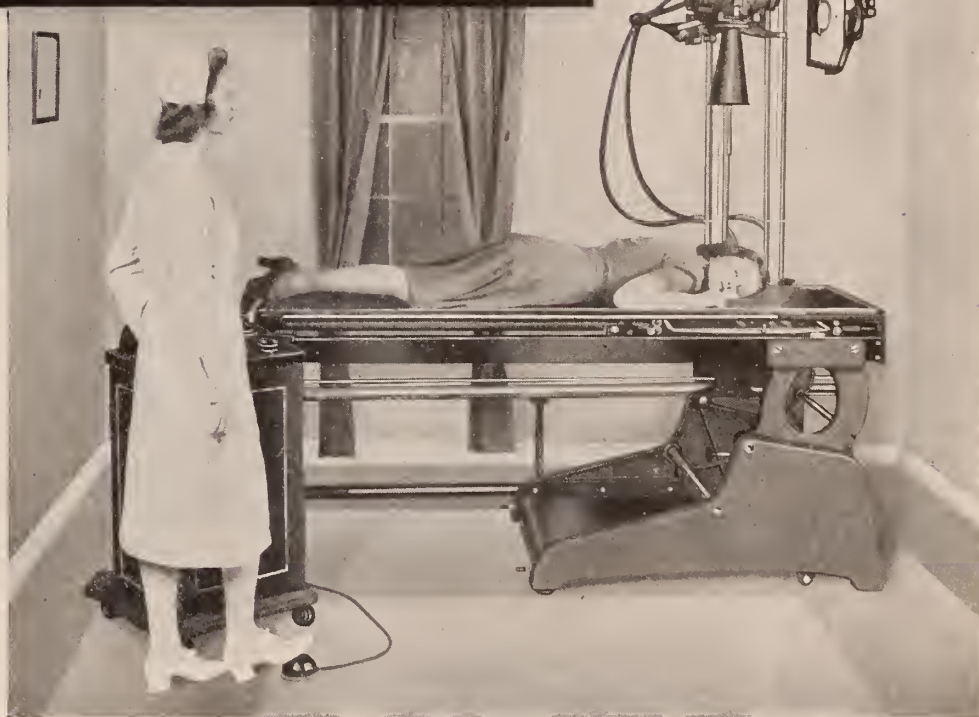
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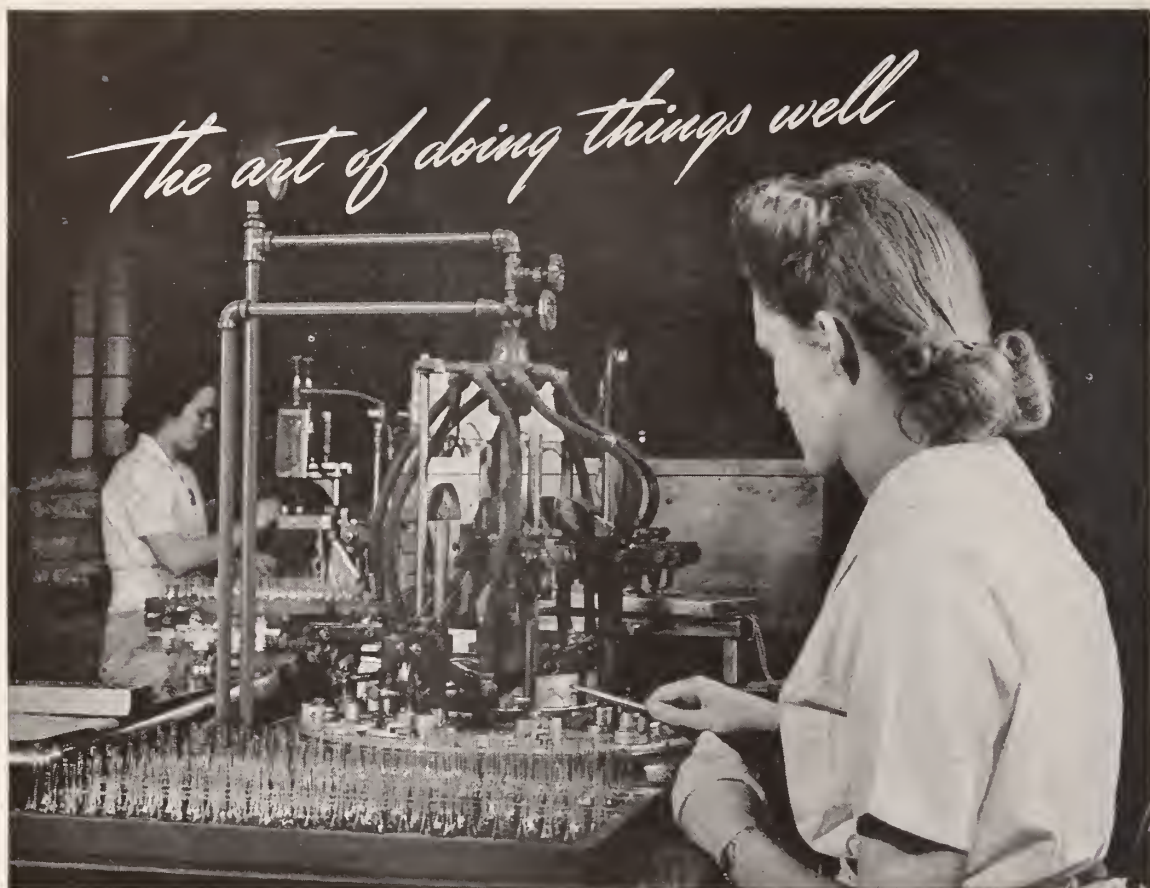
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# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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DIRECTION OF THE  
COMMITTEE ON PUBLICATION



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HENRY A. DAVIDSON, M.D., Editor  
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## HISTORY REPEATS ITSELF

Our new President is the third in the Marsh Family and a worthy successor to his illustrious forebears, and to the long list of distinguished men who have preceded him in the office of President of The Medical Society of New Jersey.

Elias J. Marsh bears the name of his father and his grandfather, both of whom served the Society as President with honor and distinction. Our President has himself already proven his ability and devotion to the aims and ideals of our Society which he has served with credit and honor as Treasurer for many years, and as a Trustee and officer in preparation for his present office as President.

Dr. Marsh is a native son, being born in Paterson, New Jersey, on March 9, 1875, where he first practiced his profession. His preparation began in his home city and included Harvard University, from which he obtained an A.B.



degree in 1896. Columbia University Medical School bestowed upon him an M.D. in 1900, after which he served an internship in Bellevue Hospital in New

York and then studied in Vienna and in the famous Rotunda Hospital in Dublin. After two years of post-graduate study, Dr. Marsh returned home and began private practice in Paterson. From 1903 to 1909 he was Secretary of the Passaic County Medical Society. He became Assistant Attending Physician of St. Joseph's Hospital of that city and in 1906 decided to specialize in ophthalmology. He joined the staff of the Paterson General Hospital as Associate Ophthalmologist and also served as Assistant in the Knapp Eye Hospital in New York City. In January, 1919, Dr. Marsh was commissioned as Captain in the Medical Reserve Corps of the U. S. A. and served in the Base Hospitals at Camp Shelby in Mississippi and at Camp McClelland in Alabama. At the close of the war, he returned to Paterson and resumed the practice of his specialty. In 1922 Dr. Marsh was elected President of Passaic County Medical Society and of the New Jersey Sanitary and Health Association,

in which he still maintains an active interest.

In 1923 Dr. Marsh became Attending Ophthalmologic Surgeon in the Paterson General Hospital and Senior Assistant Surgeon at the Knapp Memorial Hospital. He resigned the latter position to become Executive Surgeon of the Paterson Eye and Ear Infirmary.

Dr. Marsh is a Lieutenant-Colonel in the Medical Reserve Corps; Surgeon Emeritus, Paterson Eye and Ear Infirmary; Consulting Ophthalmic Surgeon to the Paterson General Hospital and Valley View Sanatorium, and holds memberships in the Academy of Medicine of Northern New Jersey, and in the Robert McKean Medical History Club. He is a Past President of the Harvard Club of New Jersey and a Warden of St. Mark's Church of Paterson.

Of our President we who know him best can truly say that he is one who  
 "Sets the Cause above renown and  
 loves the Game above the prize."

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### LOOKING FORWARD

We are entering a new year in which it takes courage to continue our investigations and experiments to improve at our own expense the services we offer for the public good. Many of our members are already serving at great sacrifice in the armed forces of our country. We cannot foresee the events of the future, nor can we determine the general trends which may be followed. Yet the responsibilities and duties which face those who remain behind to carry on in New Jersey the work of The Medical Society and of the profession, will be carried out to the best of our ability and resources. We must sharpen our focus on our proper scope of function, carefully plan our activities and conduct them with economy and effectiveness, and select our measuring rod of accomplishment so that

our claims may be substantiated to the satisfaction of any reasonable person.

Our Committees will give prior consideration to our *wartime* needs. They will keep the Executive Office informed of their aims and objectives for the year, their plans and activities, the subjects discussed, the agreements or decisions reached and the specific recommendations made to the appropriate committee or officer. Our most important project is our *Medical Service* experiment, in which we shall continue to coöperate fully or declare our failure. Our investment is not only financial, but is also personal and professional. Success can come only if all of us do our full share. Details of our efforts and the part which each can play are found in our *Journal* outlined from records in the Executive

Office, where the Committee reports are preserved.

A full-time staff devotes itself exclusively to the interests of the profession in New Jersey represented in our membership. The Executive Board with their Executive Officer on full time, is made up of your Officers and elected Trustees and this Board has the executive authority ad interim of meetings of the House of Delegates to direct the efforts of the Society. Your President is the most influential voice on this Board, but has but a single vote in its decisions. His is a great honor—and a sentence at hard labor during his term of office. Perhaps we un-

consciously have demanded an unreasonable amount of his time considering the fact that he is a busy practitioner of medicine. Last year at Cleveland, Dr. Frank Lahey, President of A. M. A., announced his belief that much of the details of work carried on need not come to the personal attention of the President. The House of Delegates agreed when he announced his determination to concern himself chiefly with principles and policies coming up for discussion in the Councils—leaving the detailed accomplishment to the technical staff members engaged for that purpose. This seems eminently fair and desirable.

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## RESEARCH

Medical men are familiar with *research* that has provided opportunity for experiment to find the solution of our professional problems—as they arise in our medical practice. Without such opportunities the practice of our profession would still be greatly hampered and retarded. Many of medicine's greatest contributions have been evolved out of research efforts. Now the large and growing problem is to provide wider opportunity for those in need of our services who for several reasons—chiefly economic—have so far not received adequate medical benefit from our profession. This newer problem of distribution of medical services and of their resultant cost must be solved as satisfactorily, as completely and as economically as we have solved our professional problems, and it can be best done in the same way—through research.

Industrial leaders, farmers, even those who are directing the many phases of our gigantic struggles to win the war, depend in large measure these days upon research. They may call it by another name but it is research. Millions of dollars are being spent right now in research efforts aimed to increase our distribution

of armed forces and their ability to kill human beings who, like disease and accidents, threaten our very existence.

Why should members of The Medical Society of New Jersey complain about money well spent in the *research* endeavors to find ways more economic and efficient to distribute our services and save human beings in need of medical attention. Our concern as physicians is to insure the professional integrity and excellence of the medical services rendered to patients, under any plan. Distribution and sales of prepaid service contracts is a problem primarily for business and insurance trained personnel, actuaries, administrators, and others in whom we have confidence, because we have seen them solve similar problems of distribution and costs. These are not primarily medical problems, though they do have medical implications which must be protected, in our research efforts. We cannot reach the solution through further discussion alone. We *must* carry on with *research*. It is to the credit of our Society that at the recent Annual Meeting in Atlantic City, our Delegates said "Go Ahead" with this research, for another year at least.



# THE WAR

## APPOINTMENTS IN THE ARMY OF THE UNITED STATES (MEDICAL DEPARTMENT)

1. On April 15, 1942, the commissioned strength of the Medical Department, Army of the United States (all components) was:

Medical Corps .....	13,500
Dental Corps .....	3,470
Veterinary Corps .....	785
Medical Administrative Corps .....	1,516
Sanitary Corps .....	423
Army Nurse Corps .....	9,000

The total computed requirements for the calendar year 1942 are:

Medical Corps .....	27,115
Dental Corps .....	6,050
Veterinary Corps .....	1,727
Medical Administrative Corps .....	2,612
Sanitary Corps .....	690
Army Nurse Corps .....	18,114

As the military situation develops and greater numbers of professional units must be provided for theaters of operations, these requirements must necessarily be increased.

2. *The shortage in Medical Officers is acute.* With the exception of first year interns who will be placed on duty in July, officers of upper field grades for whom there are no appropriate assignment vacancies at this time, and a few officers whose active duty has hitherto been deferred, the Organized Reserve of Medical Officers has been exhausted. Filler and loss replacements that cannot be furnished from the Officers' Reserve Corps, or from graduates of Officer Candidate Schools, must be procured from civil life.

3. In the procurement of physicians from this source, the Procurement and Assignment Service of The Office of Defense Health and Welfare Services has been of inestimable value. Its participation in the procurement efforts, however, does not relieve the Medical Department of the responsibility of furnishing the qualified officers necessary to meet the requirements of the increasing armed forces. Active efforts on the part of all officers in the Medical Department must be instituted to recruit the classified and unclassified physicians for appointment in the Medical Corps, Army of the United States.

4. In forwarding approved applications to The Adjutant General, the recommendations of the Surgeon General must indicate the appropriate grade, contain the statement that the appointment is within the authorized procure-

ment objective for the particular category, show clearly that the applicant possesses special qualifications appropriate to the position to which he will be assigned if commissioned, and state that no qualified officer is available for such assignment.

5. In order that all concerned in the procurement of additional Medical Department officers may give uniform advice to all applicants, the following resumé of the policies which broadly govern the recommendations to be made to the Adjutant General are published for your information and guidance:

### a. Basic considerations:

(1) Appointments in the Army of the United States (Medical Department) will be recommended by the Surgeon General to fill authorized position-vacancies for which no qualified Medical Department officers are available. The recommended applicants must possess the special qualifications required for such positions.

(2) Since no training or experience in civil life is analogous to that afforded by active military duty, no initial appointments will be recommended in grades above the lowest for assignment to tactical units.

(3) Position-vacancies calling for grades above the lowest will, so far as possible, be filled by the promotion of qualified officers on active duty.

### b. Policy governing grades for various sections:

(1) Medical Corps. All appointments will be recommended in the grade of first lieutenant with the following exceptions:

#### (a) Captain:

1. Eligible applicants between the ages of 37 and 45 will be appointed in the grade of captain by reason of their age and general unclassified medical training and experience.

2. Below the age of 37, the following recognized training and experience will be considered in recommending initial appointments in the grade of captain: certification by an American Specialty Board; Fellowship, American College of Surgeons or American College of Physicians; membership in other nationally recognized qualifying society or association; or the formal hospital training equivalent to that required by an American Specialty Board;

or other recognized training appropriate to the assignment for which recommended.

3. Eligible applicants who previously held commissions in the grade of captain in the Medical Corps (Regular Army, National Guard of the United States, Officers' Reserve Corps) may be appointed in that grade provided they have not passed the age of 45.

(b) *Major:*

1. Eligible applicants between the ages of 37 and 55 for whom there exist appropriate position-vacancies, who are qualified for appointment as *captain* as outlined in paragraph (1) (a) 2 above, and whose additional training and experience justify initial assignment as Chief of Service or Section or Executive Officer in a large military hospital, or other appropriate position, may be appointed in the grade of major.

2. Applicants previously commissioned as major in the Medical Corps (Regular Army, National Guard of the United States, Officers' Reserve Corps) whose training and experience qualify them for an appropriate assignment may be appointed in the grade of major, provided they have not passed the age of 55.

(c) *Lieutenant Colonel and Colonel:*

1. In view of the small number of assignment vacancies in the grades of lieutenant colonel and colonel, and the large number of Reserve Officers of these grades who have not been ordered to active duty, such appointments will be lim-

ited to specially qualified applicants required for specific position-vacancies which cannot be filled by promotion or by the activation of qualified Reserve officers.

*Note:* a. There are in the age group 24-45 more than a sufficient number of eligible, qualified physicians to meet Medical Department requirements. It is upon this age group that the Congress, through the Selective Service Act, has imposed the definite obligation of military service. Applicants beyond this age will be considered for appointment only if they possess the special qualifications required for assignment to positions appropriate for the grade of major or above.

b. Appointment for assignment to affiliated Medical Department units are made under special War Department authorization, and in grades authorized by appropriate tables of organization upon recommendation of the authorities of the sponsoring institution.

6. Miscellaneous:

b. There are no appropriate assignments for osteopaths, chiropractors, chiropodists, optometrists, etc., as commissioned officers. Accordingly, as such, they are not eligible for appointment in any section of the Medical Department, Army of the United States. Should they enter the military service as enlisted men, they may be considered for advancement to noncommissioned officer grades or to specialists' ratings dependent upon the existence of appropriate vacancies. If graduated from an Officers Candidate School, their assignments will be entirely nonprofessional.

## APPOINTMENTS IN THE NAVY OPEN TO MEDICAL STUDENTS

Applicants for appointments as Acting Assistant Surgeon (Interne) are required to be citizens of the United States, to have completed at least three years of medical education in a class "A" medical school and to meet the physical and other requirements as set forth in the circular of information for appointment in the Medical Corps of the Navy. Circulars are obtainable upon request to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.; the Director, or Senior Medical Officer of Naval Officer Procurement, 33 Pine Street, New York, N. Y. Examinations for appointment as Acting Assistant Surgeon (Interne) are held each year, usually during the months of June, October, and January, at all of the larger Naval Hospitals and at the Naval Medical Center, Washington, D. C. Successful candidates from these

examinations receive their appointments following the successful completion of their medical education.

Appointments as Acting Assistant Surgeon (Interne) are for 18 months duration. An Acting Assistant Surgeon, after one year of Naval internship, may apply for, and take the examination for Assistant Surgeon, U. S. Navy. Acting Assistant Surgeons (Internes) serve a rotating internship in a naval hospital accredited for interne training by the Council on Medical Education and Hospitals of the American Medical Association.

If an Acting Assistant Surgeon does not desire to qualify for appointment as Assistant Surgeon, U. S. Navy, after completion of one year of interne training, he may apply for appointment as Lieutenant (junior grade) MC-

V(G) U. S. Naval Reserve, and continue on active duty as such during the present emergency.

Completed application forms, together with the required data, must be received in the Bureau of Medicine and Surgery at least three weeks prior to the date of examination.

Assistant Surgeons and Acting Assistant Surgeons while on active duty receive the pay and allowances of a Lieutenant (jg) which for officers without dependents is \$2699 per year, and for officers with dependents is \$3158 per year. On reporting for active duty a uniform allowance of \$250 is granted.

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### APPOINTMENTS IN THE NAVAL RESERVE OPEN TO MEDICAL AND DENTAL STUDENTS

Medical and dental students, pre-medical and pre-dental students are eligible for commissions as Ensigns, Hospital Corps Volunteer Probationary (Class H-V[P] USNR).

Age limits 19 to 30 years.

Requirements:

Medical students of all classes of class "A" medical schools and pre-medical students who have been accepted as first-year students in medical schools accredited as class "A" by the Council on Medical Education and Hospitals of the American Medical Association.

Dental students of all classes of accredited dental schools and pre-dental students who have been accepted as first-year students in dental schools accredited as class "A" by the American Dental Association.

If the physical examination is made at any other activity than the Office of Naval Officer Procurement, 33 Pine Street, New York, N. Y., a report of it is forwarded to that office. Having passed the prescribed physical examination application papers and instructions for appointment as Ensign H-V(P) USNR will be issued to candidates by the Director of Naval Officer Procurement.

Ensigns H-V(P) USNR upon graduation will be reappointed Lieutenants (junior grade)

Medical Corps or Dental Corps, USNR, and those of the Medical Corps are not considered as available for active duty until the completion of at least a year's internship in an accredited hospital for interne training.

A statement from the Dean that a pre-medical or pre-dental student has been accepted for enrollment in the first coming semester and for those already enrolled in medical or dental schools, that the student is in good standing is required.

Candidates are required to pass a physical examination by a Naval Medical Officer as the initial procedure in making an application. The physical examination may be made at any activity where a Naval Medical Officer is available; Office of Naval Officer Procurement, 33 Pine Street, New York, N. Y.; Navy Recruiting Station, Albany, N. Y.; Buffalo, N. Y.; Rochester, N. Y., or New Haven, Conn., and Marine Recruiting Station, Syracuse, N. Y.

Uniforms are not prescribed until ordered to active duty, when a uniform allowance of \$250 is granted. The pay for officers of the rank of Lieutenant (jg) USNR, when on active duty, is \$2699 per year (without dependents), and \$3158 per year (with dependents). Ten per cent increase in base pay is provided when an officer is on sea duty.

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### APPOINTMENTS IN THE NAVAL RESERVE OPEN TO MEDICAL DOCTORS

*Volunteer General Service Class:* An applicant must be a graduate of a medical school listed as Class "A" by the Council on Medical Education and Hospitals of the American Medical Association to be commissioned, otherwise he must demonstrate his professional qualifications by such written, oral or practical examinations as may be prescribed by the Bureau of Medicine and Surgery. An applicant must not be over 35 years of age, and must have been a citizen of the United States for ten years, and if a year's internship in an accredited hospital for interne training is not completed, active duty orders will be deferred

until that date. The only rank open to applicants for Volunteer General Service Class is Lieutenant-Junior Grade.

*Volunteer Special Service Class:* An applicant, in addition to the professional qualifications for eligibility for Volunteer General Service Class, must demonstrate that he is a well-trained specialist in his field, by his training in his specialty, hospital and teaching positions, memberships and fellowships in medical or surgical associations, and contributions to medical literature. An applicant must be under 50 years of age and a citizen of the United States for 10 years.



The rank based on age requirements for which one may apply is as follows:

Lieutenant Commander ..... 37 to 49 years of age  
Lieutenant-Senior Grade ..... 33 to 44 years of age  
Lieutenant-Junior Grade ..... 27 to 38 years of age

Uniforms are not prescribed until ordered to active duty, when a uniform allowance of \$250.00 is granted. The pay for the officers of the rank of Lieutenant Commander, when on active duty, is \$3936 per year (without dependents), \$4848 per year (with dependents). Rank of Lieutenant is \$3336 per year (without dependents) and \$3792 per year (with dependents). Rank of Lieutenant-Junior Grade is \$2699 per year (without dependents) and \$3158 per year (with dependents). There is an increase in base pay after each three-year period of service. Ten per cent increase in base pay is provided when an officer is on sea duty. Expense for traveling under orders at the rate of eight cents per mile is allowed. Officers and their dependents are eligible for free medical and hospital care in the Navy.

Candidates are required to pass a physical examination by a Naval Medical Officer as the initial procedure in making an application. The physical examination may be made at any ac-

tivity where a Naval Medical Officer is available: Office of Naval Officer Procurement, 33 Pine Street, New York City; Navy Recruiting Station, Albany, New York; Buffalo, New York; Rochester, New York, or New Haven, Conn., and Marine Recruiting Station, Syracuse, New York.

Having passed the prescribed physical examination and the report received in the Office of Naval Officer Procurement, application papers and instructions will be mailed to the candidate. When application papers are received in the Office of Naval Officer Procurement and found to be complete for forwarding to the Navy Department, Washington, D. C., a letter will be written to the Applicant's Selective Service Board requesting deferment until final action is taken.

It is not necessary for candidates for commissions in the Navy Medical Corps Reserve to be cleared through the Procurement and Assignment Service before filing their applications.

If not convenient to come in for a personal interview, inquiries may be made by writing to the Director or Senior Medical Officer, Naval Officer Procurement, 33 Pine Street, New York, New York.

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## EMERGENCY MEDICAL SERVICE REPORT

March 6, 1942

At previous meetings of this Committee we have reported upon special subjects or special phases of the defense program having health implications. Today we wish to render a report on the progress and present status of arrangements to provide emergency medical services in case of belligerent action.

### 1. LOCAL REACTION

For four months we have been studying this problem and arranging for the organization of emergency medical services in each of the communities of New Jersey. We have worked in accordance with the New Jersey Defense Laws, the policies of the New Jersey Defense Council, and the policies and suggestions of the Federal Office of Civilian Defense as forwarded to us from the Regional Office by Dr. H. Van Zile Hyde.

In many of the communities we have met with the complacency and indifference which characterized the defense effort prior to December 7. This is now much less in evidence. We have met and are still meeting with some lack of coöperation, personal and group ambitions, petty differences difficult of reconcilia-

tion, and disregard for the defense laws and intent of the defense program. This has resulted in confusion and lack of adequate progress in some of our communities. In the majority of the communities we now find a group of persons who realize the seriousness of the situation, who realize the responsibility they are assuming, and who are willing to coöperate on a state and local level and reconcile their opinions for the good of the program.

### 2. CHIEFS OF EMERGENCY MEDICAL SERVICE

These physicians, responsible to their local councils and their communities for the adequacy of medical care rendered during an emergency, have been appointed in 515 communities. With very few exceptions the remaining communities are small towns having no physician. In the majority of cases these men are doing an excellent job; in a few instances their progress is hampered by their own complacency or local complications difficult to control.

### 3. EMERGENCY MEDICAL FIELD UNITS

These units, composed of physicians, nurses, and first aid men, constitute the basic unit of

Emergency Medical Service organization. They form the personnel for the casualty and first-aid stations, and will initiate local medical plans at the time of the emergency. The ideal Unit is composed of the resident staff of an existing local hospital. Such organization is not possible in smaller communities and must be substituted by medical and nursing personnel of the community.

To date, of our 86 general hospitals, emergency units have been organized and equipped in 74. Five special hospitals have also organized units. The distribution of these units is such that all of our metropolitan areas and industrial areas are covered, and should receive prompt medical service in any belligerent emergency.

We advise that these units not go into action as such in local or minor emergencies, but only during belligerent action or at other times when the entire defense program is effective. To do so can only mean ineffective service and lack of coordination with consequent adverse criticism, and reflection against the efficiency of the defense program.

#### 4. TYPES OF LOCAL PLANS

It is difficult to develop local plans of a uniform type on a state basis, because of the varying local facilities and requirements. There is a tendency to develop plans which are too elaborate and extensive to meet the demands of the community. Such plans are also difficult or impossible of prompt initiation. We are attempting to simplify local plans, to have them based upon the Emergency Medical Field Unit as the *initiating* unit, to be *supplemented* as necessary to meet the contingency by additional local facilities or facilities from neighboring communities.

#### 5. COMMUNITY FIRST AID AND RESCUE SQUADS

At the onset of the defense program there were about 120 of these squads. We now have record of about 140. These squads are private, incorporated squads, usually supported by local contributions, and dealing with the population as a whole, as distinct from the squads supported by industrial organization and for use within those organizations.

These squads are one of our most valuable assets, and our greatest source of ambulance transportation. To be recognized in the program they must have trained personnel, proper equipment and transportation.

To date we have complete information and an inventory of supplies on 83 squads. Another distribution of inventory blanks will be made next week, after which the delinquent will be reached by personal contact.

#### 6. RED CROSS CHAPTERS

We have 63 Red Cross Chapters. Complete inventories of all facilities have been received from 41 Chapters. Mr. Gus Meyers of the National Red Cross has recently been assigned to the State Defense Council staff to assist in coordination of Red Cross activities.

The Red Cross Chapters are all well organized. They have an abundance of trained personnel. The majority have scant facilities on hand, except for personnel. They are not adaptable to the prompt initiation of an emergency medical program, but are very valuable in the capacity of supplementing the initial effort.

They can furnish large amounts of supplies after the onset of an emergency. The majority have surgical dressings on hand. A few have complete canteen service organization and equipment capable of feeding several thousand persons. Motor corps personnel will be of value in transportation problems. Red Cross staff assistants are available for clerical and administrative work during an emergency.

Forty-two hospitals are training or will train Red Cross Nurses Aides in collaboration with 48 Red Cross Chapters.

Thirteen thousand persons have graduated from Red Cross First Aid Classes in the last seven months.

Every effort will be made to utilize these facilities to supplement emergency medical services.

#### 7. AMBULANCE FACILITIES

Ambulance facilities are insufficient. We are not ready at present to report upon the exact number or distribution of existing ambulances, but through our community inventories and reports from the State Department of Licensure we hope soon to make such a report.

The Laundry Owners Association has made available 3,800 laundry trucks with ambulance type bodies, which they will equip with first aid equipment for use in communities making such a request. One community to our knowledge has taken advantage of this offer.

#### 8. SUPPLIES

An "Inventory of Supplies" being submitted by individual communities discloses a surprising amount of available supplies throughout the State. The average community has sufficient for the initiation of its plan. This supply can be supplemented by neighboring or state supplies when needed during an emergency.

From the "Medical and Surgical Relief Committee" we have received twelve complete equipment units which have been donated to needy community hospitals. From the "Or-

anges" we have forwarded a check which will provide five additional units.

We have estimated the supply needs of all communities with population of over 10,000 people. This was done with a view to allocating federal supplies should they be made available.

#### 9. HOSPITAL FACILITIES

Dr. Emil Frankel has been appointed to our staff as "State Hospital Officer". The first phase of Dr. Frankel's work will be to determine the normal capacity of each general hospital and its expansion possibilities based upon installation of additional beds and the discharge of convalescent patients.

The second phase of his work will be the determination of sites and facilities for base hospitals in rural areas to supplement our existing hospital facilities when needed.

#### 10. NURSING FACILITIES

To assist local Chiefs of E. M. S. and hospitals in obtaining additional nursing personnel, Miss Elizabeth Curtis has been appointed to the defense staff. Through her efforts and the efforts of key nurses in each county the number of available nurses in each community will be determined. The work has progressed far enough at present to enable us to be of assistance to any local Chief of Emergency Service.

#### 11. GAS DECONTAMINATION

Decontamination stations will be under the jurisdiction of local Chiefs of E. M. S. The administration of these stations will be delegated to local Health Officers.

Three physicians, Dr. Snegireff, Dr. Kilduffe and Dr. Casilli, have recently attended the Physicians Gas School conducted at The University of Cincinnati. These men are now available as instructors to other groups.

#### 12. SUMMARIES OF BRANCH AREAS

*Area No. 1:* Hudson, Bergen and Passaic Counties. No recent report has been received from the Branch Office of this area. We do

know that local plans to cover the needs of the larger communities of this area are progressing quite satisfactorily. Jersey City, Hoboken and Paterson are well organized. Until recently the communities of Bergen County have done little. Dr. Francis J. McCormack has recently been appointed as Deputy in this county and reports that all communities in his county are now organizing with the exception of 11, mostly small communities.

*Area No. 2:* Essex and Union Counties, plus Harrison, Kearny and East Newark. This area is well organized, and while some of their plans are not completely satisfactory they are all making satisfactory progress.

*Area No. 3:* Morris, Warren and Sussex Counties, plus a few towns in Passaic County. This area is well organized except for four small communities.

*Area No. 4:* Middlesex, Somerset, Hunterdon and Mercer Counties. No report has been received since February 25. At that time 28 of the 85 communities had not organized. The larger communities, including Trenton, New Brunswick, and Perth Amboy, are well organized and making satisfactory progress.

*Area No. 5:* Monmouth and Ocean Counties. This area is well organized on an inter-county basis by a plan meeting the needs and approval of each community. The plan is not conventional in type, but quite satisfactory. Three small communities in Ocean County are not completely organized.

*Area No. 6:* Cape May, Cumberland and Atlantic Counties. All communities in this area are well organized with the exception of four small towns with population of less than 1,000 persons.

*Area No. 7:* Camden, Burlington, Gloucester and Salem Counties. A report on March 3 indicates that all communities adjacent to the Delaware River, their vulnerable area, are well organized and have satisfactory plans. It is estimated that 90 per cent of the physicians in this area are involved in local plans.

CHARLES H. SCHLICHTER, M.D.,  
Chief, Emergency Medical Service.

### TEMPORARY HOSPITALIZATION AND MEDICAL CARE—NECESSITATED BY ENEMY ACTION TO CIVILIANS

An Emergency Medical Section has been established in The U. S. P. H. S. A Hospital Section has been established in the Medical Division of the O. C. D. These services will be operated under a common chief.

Regional Medical Officers of the O. C. D. will act as the regional representatives of the two above-mentioned Federal Agencies.

Administrative, clerical and other personnel will be assigned to assist in these duties as needed by the Regional Medical Officer.

State Chiefs of Emergency Medical Service may function for their States as responsible agents of the O. C. D. and of the U. S. P. H. S. in the organization of emergency hospital facilities, and in the approval of vouchers by



the U. S. P. H. S. The Regional Chief will approve the State Chiefs or their deputies for commission in the U. S. P. H. S. Reserve on full time or as "Special Consultants" on part time, while retaining inactive status as U. S. P. H. S. Reserve Officers.

In some states a State Hospital Officer will be appointed to assist on full time the State Chief of E. M. S. and the Regional Medical Officer of the O. C. D.

The Field Staff of the Medical Division of O. C. D. will be responsible in carrying out this program with other federal and state agencies, public and private, but the authority lies with the federal agencies under this set-up and the cost involved in the carrying on of the work by the State and local agencies is not borne by the federal agencies though they have the final authority, involving both medical and hospital services integrated in this plan when its operation is "necessitated by enemy action".

The State Chief Emergency Medical Officer is responsible for enlisting local physicians as Local Chief E. M. S. Officers to enlist local doctors as reserve doctors in U. S. P. H. S., who are likely to remain available for O. C. D. participation in emergency hospitals for the care

of evacuated persons in reception areas, when ordered by the Surgeon General (of U. S. P. H. S.). Physicians so commissioned in U. S. P. H. S. will remain on the inactive roll (without salary) until called to service.

The general policy will be to solicit primarily the medical staffs of leading civilian hospitals for this purpose to staff emergency hospitals which will be affiliated with large urban hospitals, or groups of hospitals wherever feasible. Physicians in private practice will be encouraged to apply for reserve commissions. As far as possible service for such Reserve Officers will be in the area in which they reside. The recommendations for Reserve Officer Commissions in U. S. P. H. S. will go through the Regional Medical Officer O. C. D. (Dr. Van Zile Hyde), to the Surgeon General U. S. P. H. S. (Dr. Parran). Funds of F. S. A. will go to U. S. P. H. S. to reimburse local hospitals (casualty), base hospitals in addition to U. S. P. H. S. providing the necessary medical and dental staffs. All hospitals in the nation may serve as casualty stations of the E. M. S. at per diem rate of \$3.75. Additional costs are not a federal responsibility unless specifically authorized in exceptional circumstances.

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## DRUG MONOPOLY SEEN AS THREAT TO CONTROL OF MALARIA

The fight against malaria, a killing and disabling disease affecting several million residents of the United States, now faces a double handicap, the staff of *Medical Care* warns in an article entitled "Monopoly Over Malaria?" published in the spring issue of the quarterly journal.

The Japanese conquest of Java cut off from the United Nations more than 90 per cent of the world supply of cinchona bark, from which quinine is manufactured. Although existing stocks in the United States should last for slightly more than two years, *Medical Care* foresees heavier demands for army and civilian needs in the South and for troops in malarial regions abroad.

Two synthetic substitutes for quinine are produced, and the patents for these processes present the second obstacle. As in the case of synthetic rubber, the great German chemical trust — I. G. Farbenindustrie — has exercised tight control over atabrine and plasmochin, the coal tar derivatives that constitute with quinine the only known specifics for treatment of malaria.

The I. G. F. licensed the Sterling Products Company to manufacture atabrine and plasmochin for sale in the United States. An anti-

trust action by the Department of Justice forced Sterling to break off its relations with the German trust last September, but so far as *Medical Care* has been able to learn, the American firm has not permitted any other manufacturer to use its patents.

"All things considered, the shortage of quinine would probably not be a threat of major proportions, provided the synthetics were available in sufficient amounts at reasonable cost," the article comments. But evidence assembled by the staff of *Medical Care* points to the operations of an international cartel in limiting production and maintaining a high price for both the natural drug and its substitutes. Recently the president of Sterling Products announced that the production of atabrine would be increased but nothing was said about the price.

Under existing federal war powers, and with no loss to national health, quinine could be eliminated from so-called hair tonics, from compounds such as certain "laxative tablets" sold for colds, and possibly from other non-essential remedies sold for self-medication. Such action should be taken at once by the War Production Board. Thus the shortage of quinine could be helped somewhat.

Suggesting that the patent laws be amended to provide fair returns for discoverers and manufacturers of new drugs but to prevent restricted production and prices beyond the reach of many patients, the article concludes:

"The present situation of quinine and its substitutes makes clear that it is not in the public interest to have the ownership and control of a medical discovery of wide public importance remain irretrievably for 17 years in

the hands of individuals or agencies which can exploit them for their private advantage, despite a national emergency."

*N. B.*—Hearings before a Committee of the Senate are announced for April 13, on the O'Mahoney-Bone-La Follette bill, recently introduced in the Senate. This bill provides for a system of licenses open to all, to be established for any patented process upon a declaration by the President that such action is essential to the national defense.

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## BLOOD COLLECTIONS FOR ARMY AND NAVY

For the first two weeks in March, 30,477 blood donations are reported by the Red Cross Chapter operating blood donor centers in eighteen cities. This service was inaugurated in February, 1941, at the request of the Surgeons General of the Army and Navy. For the year beginning July 1, 1942, the Army and Navy have requested of the Red Cross a minimum total of 930,000 units, which will require more than 1,000,000 donors.

In the first seven months of operation the blood donor centers of the Red Cross had delivered to processing laboratories a total of 27,352 donations. In February, the shortest month of the year, 53,780 donations were made, and the first two weeks of March indi-

cated a response of 65,000 for that month. There is therefore every prospect that the goal set will be reached, provided the present rate of donations are maintained without let-up. It is hoped that this figure can be increased, since there is probability that additional amounts will be requested by the Army and Navy.

The value of blood plasma in the treatment of burns and wounds and in combating shock was amply demonstrated at Pearl Harbor. Surgeons on duty there during the attack and in the day following state in no uncertain terms that many lives were saved due to the use of plasma supplied to the armed forces by the local medical society, the American Red Cross and other agencies.

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## MEDICAL PREPAREDNESS IN NEW JERSEY

Dr. Charles H. Schlichter, Chairman of the Committee on Medical Preparedness of The Medical Society of New Jersey, reports that about six weeks ago he was appointed New Jersey representative of the Procurement and Assignment Agency by Mr. Paul V. McNutt. Dr. Schlichter selected a committee of four men to assist him and appointed in each county a confidential representative to inform the Committee of the availability of each physician whose name is submitted to him through the Procurement and Assignment Service. Things have gone well and all questions have been settled satisfactorily so far as the passing upon the availability of physicians is concerned. Due to a difference in opinion between the Regional Director and the State Director regarding the handling of physicians classified as 1A by their draft boards, whom the Committee aims to prevent being inducted into the ranks by the State Induction Boards, New Jersey has been able to offer constructive improvements which have been acknowledged and appreciated by Colonel E. N. Bloomer, Acting State Director for Selective Service in New Jersey. Colonel Bloomer's letter of April 1 is quoted as evi-

dence of his appreciation of the coöperation and assistance given him by Dr. Schlichter's Committee.

I am most pleased to receive a copy of your very comprehensive report covering the work of the Procurement and Assignment Service. Undoubtedly, it will do much to clarify the present conditions, which have not been entirely satisfactory in that a majority of the members of the medical profession have not fully understood the relationship with Selective Service.

As I have previously stated, we are only too happy to coöperate with your Committee in obtaining necessary deferments for physicians who have been classified 1A pending action by the War Department on their application for commission in the Armed Forces, and also in obtaining occupational deferments for those physicians who are required in their local communities. It is realized that the time element will not always permit the reference of such cases to Dr. Booth in Elmira and should you at any time have a case which requires immediate action, it is suggested that you refer the matter direct to this headquarters.

It is necessary to the accomplishment of the aims of both groups that the Procurement and

Assignment and the Selective Service Agencies establish mutual confidence and coöperation. There was naturally some misunderstanding and confusion incident to the establishment of the Procurement and Assignment Service work at a later date than the Selective Service, but with the constructive suggestions offered by Dr. Schlichter's Committee, these have been kept at a minimum in New Jersey. The interest of the medical profession in New Jersey has been preserved through the fine work of

our Medical Preparedness Committee as it relates to the doctors classified as 1A.

Dr. Schlichter, in addition to his position as Chairman of the Medical Preparedness Committee of The Medical Society of New Jersey, is now the official representative of Procurement and Assignment Service as well as the State Defense Council, and the integration of the functions of these three agencies has been in the interest of the profession as well as of the citizens of New Jersey.

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## SHORTCOMINGS IN CAMPAIGN FOR PHYSICAL FITNESS

"It is regrettable that American physical education has leaned more and more heavily within recent years on the social sciences and on education. If its contemporary aspirations are to improve the fitness of man power at all age levels and in both sexes, it must be encouraged to reset its biologic roots." Thus does F. A. Hellebrandt, M.D., Madison, Wis., sum up in the current issue of *War Medicine*, published by the American Medical Association in coöperation with the Division of Medical Sciences of the National Research Council, an article in which she points out the lessons that this country may learn from the failure of physical fitness campaign endeavors in England during the past few years.

"The current interest of various professional groups and government agencies in the physical welfare of the American people seems to be a reflection of a world movement. The American physician now is being faced with an unprecedented opportunity to guide proposed fitness programs into channels of sound preventive medicine. \* \* \*

"Little is known of the physiologic influence of the various exercise systems. As yet no scheme of physical training has been founded on exact knowledge of the effects of this age-old therapeutic and prophylactic measure on the machinery of the human body. Physical training still is based largely on empiricism. A British correspondent gave the following plausible reason for this status:"

If a person is aware of something wrong with his mechanism he should go to some expert who will tell him what to *do* to put it right; whereas, of course, he should act on the opposite principle and go to an expert who will tell him what he *is doing* to bring about his wrongness, and who will show him *what not to do* to enable him to stop doing the thing that is causing the wrongness. Now all systems of what generally is known as physical culture are based on the former principle, and therefore their only function is to deal with the symptoms and not with the origins of the misuse; and, as symptoms differ widely, we have these diversified methods of curing them, while leaving their cause untouched.

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## BOOKS FOR MEN IN SERVICE

Librarians the country over are collecting and sorting volumes donated by the people of the United States for the men in the present armed forces. The books are taken to public libraries and other collection points all over the country, where they join the *Victory Book Campaign*, sponsored by the American Library Association, American Red Cross, and United Service Organizations, and seeking ten million good books for the study and recreation of our soldiers, sailors and marines.

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## AVIATION MEDICINE

Many physicians are interested in aviation medicine. Information blanks may be secured from the Office of the Air Surgeon, Army Air Forces, Washington, D. C. Twenty-five hundred medical officers are needed for this service by July 1, and 600 per month for the balance of the year. Of the men selected, 80 per cent must be under 36, 20 per cent may be between 36 and 45, provided they are recognized specialists, particularly in traumatic surgery, ophthalmology or neuro-psychiatry.

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## SCHOOL BUS AMBULANCES

Blairstown, N. J., has converted with satisfaction and economy their school buses into ambulances, and Frank S. Gordon, M.D., has contributed a description with estimated costs

and construction plans for such conversion. Those interested can obtain information by writing to Dr. Gordon, Blairstown.



# ORIGINAL ARTICLES

## MODERN TREATMENT OF URINARY TRACT INFECTIONS

By MORTIMER REICH, M.D., M.Sc. (Med.), Newark, N. J.

Read by invitation at the Newark Department of Health Staff Meeting, October 14, 1941

Marked advances in the chemotherapy of urinary tract infections have put us in the position where a logically planned and carefully executed attack will lead to the rout of practically all bacterial invaders of the urinary system.

### IDENTIFICATION OF ORGANISM

The first essential is to identify the organism, since we have many excellent drugs, each one suited for the destruction of one definite type of bacterium.

The best method of identification is to examine the centrifuged urine sediment stained by Gram's technique. This stain can be done in two or three minutes and affords an excellent method of differentiation. The colon group, proteus bacillus, and gonococcus, which will not be discussed here, give a Gram-negative or red stain. The other common organisms are Gram-positive or dark blue.

In the female, a catheter specimen of urine is essential. In the male, the so-called "sterile" specimen will suffice. This may be obtained by washing the penis carefully with green soap and water, followed by a mild antiseptic solution. The patient then voids; the first half of the yield contains washings from the surface of the normally contaminated urethra and is discarded. The second half is voided directly into a sterile container.

The next step is determination of the pH of the urine. The pH is a standard of measuring the reaction, or degree of alkalinity of the urine. It is a measure of the hydrogen ions. Seven is the neutral point; urines higher than that are alkaline and those with a pH under seven are acid.

One may ask, "Why not ordinary litmus paper determinations?" The answer is that litmus is not accurate enough. It is a qualitative, not a quantitative reaction, which determines acidity and alkalinity, but not its degree.

A simple, yet accurate way, is with nitrozone (Squibb) paper. It is as easy to use as litmus. One drop of urine is placed on the paper; and after thirty seconds, the color is read against a standard chart. We have compared over fifty readings by this method against the La Motte and the Hellige Klett colorimeters, and find that after a little experience in judging the delicate shadings of color, it is accurate within 0.1 per cent. The pH is of value for several reasons. It aids in differentiating between the colon bacillus and bacillus proteus, both of which are Gram-negative. The colon bacillus is normally found in an acid medium; and the proteus bacillus in an alkaline, if the urine has remained in the bladder long enough, as is usually the case, for the infecting organism to break down the urea, liberating ammonia.

Remember too, that the pH must be carefully regulated for effective therapy in certain cases.

The third step in the identification of the organism is by culture. This is of great confirmatory value, but is not always practical in ambulatory patients. A Gram stain of the sediment of freshly voided urine examined by a trained observer offers less chance of error, for in a urine culture, contamination might occur; or the organism may be attenuated by therapy and therefore may not grow in artificial media; or in mixed infection, one organism might completely overgrow the other on the culture medium.

The colon group constitutes approximately 80-85 per cent of urinary infections, the cocci about 10-15 per cent and the proteus bacillus about 8-10 per cent.

### ROUTE OF INVASION

The most common route for the bacteria is the hematogenous one. Colon groups are absorbed from the bowel, and if circumstances

are favorable, survive in the blood stream, are brought to the kidneys and embolize there. If the defense mechanism of the body is below par, growth takes place and a parenchymatous and interstitial inflammatory reaction occurs, with extension to the renal pelvis and secondary pyuria and bacteruria. The kidney is not a bacterial filter. If bacteria are in the urine, some degree of renal damage must have occurred. Obviously the term "pyelitis" is a misnomer; the word pyelonephritis should supplant it.

Other foci feeding the hematogenous path are skin lesions, upper respiratory infections, infected teeth, tonsils, and sinuses. The organism from these foci is usually a coccus; and most often lodges in the cortex of the kidney, invading the medulla and pelvis later, or not at all. In many cases, therefore, the urine may contain no pus; but culture and a careful examination of the stained sediment will reveal the coccus. This organism may produce severe fulminating multiple cortical abscesses, which often are fatal unless the disease is unilateral and is recognized early enough to permit a life-saving nephrectomy.

Less severe cases may cause a rupture of a small abscess through the cortex with a subsequent perinephritis and often a secondary perinephric abscess, which will require incision and drainage. Mild infections often have no localizing signs or symptoms, and are classified as a "grippe" unless a Gram stain and urine culture have been done.

The second method of spread is lymphogenous. The foci here are infections in the cervix, prostate, or seminal vesicles. Many a persistent pyelonephritis and cystitis has not been cleared until the foci have been eradicated.

Some authorities think that lymphatic spread has occurred from bowel to kidney, but this would require retrograde flow of lymph, which has not been proved. Nor can the ureteral lymphatics carry infection from bladder to kidney. Anatomic studies of the ureter reveal that the lymphatic drainage of the ureter is segmental, each third having its own group of nodes, so that direct spread to the kidneys by this method is anatomically impossible.

The third method of infection is urogenous, that is, by direct continuity. This almost always occurs in females, mostly children, and during an attack of enteritis or diarrhea. The bacillus, usually colon, ascends the short urethra and creates a cystitis and then a secondary pyelonephritis. We feel that this pyelonephritis is hematogenous from the bladder. Lymphatic spread is not likely and direct ascension retrograde against the flow of urine would not be likely if the uretero-vesical valves are normal.

#### PRIMARY CYSTITIS

Primary cystitis is extremely rare. Cystitis is almost always secondary to infection elsewhere in the urinary tract. A small proportion may be due to fecal contamination of the short female urethra, but even then it requires reduced resistance of the bladder mucosa, due to enteritis or some other condition lowering general resistance. Another small proportion may be secondary to infections from the female adnexa, or prostate and vesicles in the male. Except for these cases, it is safe to assume that all bacterial cystitis, with no demonstrable bladder abnormality, is secondary to pyelonephritis.

#### PREDISPOSING FACTORS

Predisposing factors may be present which favor the initiation of infection and will cause it to persist in spite of most vigorous chemotherapy. These factors are usually obstructive in nature, causing stasis of urine. Calculus, foreign body, stricture, aberrant vessels impinging and narrowing the ureteral lumen, valves, an obstructing prostate, a narrowed meatus: in short, a foreign body, or an obstructive uropathy, which may exist anywhere from renal calyx to external urinary meatus, will thwart efforts to eradicate infection until it is removed. This complication is present in one-third of the cases.

#### ACUTE FEBRILE INFECTIONS

First, consider the acute case seen in the febrile stage. Bed rest is essential, until at least forty-eight hours after the fever has subsided. Diet is immaterial; anything within

reason may be given. Fluids are the most important factor. About 4500 c.c. daily should be administered, preferably by mouth, but parenterally if necessary. This copious intake assures a steady continuous urinary excretion, which flushes the tract and prevents blockage of a ureter by pus, which is usually the cause of acute febrile exacerbation. It has a detoxifying action, and maintains fluid balance during a febrile period.

The bowels must be kept open. Milk of magnesia and mineral oil, one-half ounce of each, twice daily, is adequate, though some prefer enemata or high colonic irrigations.

The foci of infection mentioned above should be eliminated if present.

To combat acidosis, with its secondary nausea and vomiting, which is usually a portion of the syndrome of acute urinary tract infection, alkali in the form of sodium bicarbonate should be given. Two drams every four hours is sufficient.

This constitutes the entire essential treatment of the uncomplicated febrile phase of acute urinary tract infection.

Difficult as it may be to refrain from prescribing antiseptics, no chemotherapy need be instituted until forty-eight hours after the temperature has become normal. The administration of a drug with restriction of fluids to obtain concentration of the kidney would be harmful in the acute febrile stage; and if given with forced fluids, it may be valueless, since bacteriocidal concentration could not be obtained. The sulfonamides are an exception and may be given in an acute urinary tract infection. They will shorten the course of the disease. But remember,—they have potential, serious, toxic side effects. So, be careful before using these drugs unnecessarily. The febrile stage will subside completely in seven to ten days if obstruction is not present, and if the infection is not of the rare fulminating type, which causes multiple cortical abscesses of the kidney. However, Gram stain and culture will still reveal the presence of the bacteria in many cases, which will then be eliminated by the drug of choice. Four drugs are of value: methenamine, mandelic acid, sulfonamide group and nearsphenamine.

Many other drugs and methods have been used, such as changing the reaction of the urine, shifting the reaction back and forth, volatile oils such as sandalwood, hexylresorcinol or caprikol, methylene blue, salol, pyridium, benzochrome, and vaccines, but these have given only partial success. Almost all uncomplicated cases become afebrile within seven to ten days without medication. If Gram stain and culture are the criteria of cure, success by the above methods is dismally meagre. Many so-called recurrent infections are only exacerbations of latent improperly treated primary infections.

#### METHENAMINE

Methenamine is of value in mild bacillary infections of the colon type. Its action depends upon the release of formaldehyde in an acid urine. If the pH is above six, none will be liberated and the drug is wasted. The therapeutic coefficient of methenamine is directly proportionate to the acidity of the urine. A pH of 5.2 to 5.4 should be obtained. To acidify the urine, enteric coated ammonium chloride tablets should be used. Enough should be given to obtain the desired effect, and twenty-two and a half grains daily will usually suffice, but a daily check of the pH, which takes less than a minute with nitrozone paper, will determine whether more or less should be given. Ammonium nitrate is also of value.

Sodium acid phosphate, the drug most commonly used, should be discarded, for it has been satisfactorily demonstrated that it will but slightly change the pH of the urine, unless it is markedly alkaline at the onset. More than 90 per cent of urinary infections have a pH of under seven, that is, they are slightly acid and will be very little affected by sodium acid phosphate. Of course, there are cures under such a regime, but those can only be cases of spontaneous cure, or those in patients who happen to have a urinary pH below 5.5 from the very onset.

Before leaving methenamine, we will repeat that many of the failures for which it has been blamed have actually been due to insufficient acidification of the urine. Methenamine should be given in four doses daily, so that a continu-



ous concentration of formaldehyde will be present. Ten grains four times daily can usually be well tolerated. I see no real value in daily intravenous injection of the drug into an alkaline blood stream unless the urine has been properly acidified. Even then, it is not as good as divided doses which maintain a constant level in the urine.

#### MANDELIC ACID

An excellent drug for colon bacillus infections and the enterococcus or streptococcus fecalis infection is mandelic acid. It is administered in the form of calcium or ammonium mandelate, and the dose is twelve grams of mandelic acid daily for the adult. The dose for children is one and one-quarter grams per ten pounds of body weight. As with methenamine, it is best given in four divided doses. The mandelic acid is excreted by the kidneys unchanged. A pH of 5 to 5.4 is essential for bacteriocidal action. The usual procedure is to acidify the urine for a day or two before the drug is given, so that it may immediately be effective. Once treatment has been instituted, the ammonium chlorid may be reduced to about seven and a half grains, since the mandelic acid is almost sufficient by itself to maintain the proper pH. The pH should be checked at least once daily.

A second important step is the limitation of total fluid intake to between 1000 and 1200 c.c. daily, so that the necessary concentration of drug of 0.5 to 1.0 per cent may be obtained in the urine.

One week of treatment usually suffices. Before pronouncing a cure, the Gram stain and culture should be negative on two occasions, the second check-up being several days after the administration of the drug has been stopped.

The drug is of much less value in bacillus proteus and in some of the urea splitting coccal infections because proper acidification is usually impossible. These constitute about 10 to 15 per cent of urinary infections.

The only toxic effect manifested by mandelic acid is an occasional temporary renal irritation, demonstrable by red cells and casts in the urine. This promptly subsides with the

withdrawal of the drug and the forcing of fluids. I found this reaction in two of twelve hospitalized cases under treatment for chronic bacillus coli infection. After a few days, the drug was re-administered, the patients were carefully watched, and microscopic examinations of urine were done twice daily. In one case, there was no recurrence. In the second, there was a recurrence of red blood cells and casts on the sixth day. Stain and culture were negative by this time. The drug was stopped, fluids were forced, and the urine quickly returned to normal. Renal function tests were normal on repeated occasions.

Two moderately severe, but well controlled diabetics were treated with mandelic acid with no metabolic disturbances.

This drug, when properly administered, is at present the most useful one in the urologic armamentarium.

The ketogenic diet is a good means of eradicating bacillary infection, but because of its unpalatability has been completely superseded by mandelic acid.

#### SULFANILAMID

Were it not for the fact that it produces frequent and often alarming toxic effects, sulfanilamid would have precedence over mandelic acid. It is easier to administer in that it does not require acidification; indeed, it works slightly better in an alkaline urine. The drug is bacteriocidal for bacillus proteus, and for most of the urea-splitting cocci, which usually can not be destroyed by mandelic acid because of inability to acidify the urine. It is as efficient as mandelic acid in eradicating infections of the colon type. However, against the streptococcus fecalis or enterococcus, it is a complete failure. Mandelic acid will destroy these bacteria.

Dosage has not yet been stabilized, but the consensus is that fifteen grains should be administered four times a day. This will give a free sulfanilamid blood level of about five milligrams per cent, and a urine level of over fifty milligrams per hundred c.c. of urine. The drug should be given in four divided doses, so that a constant level is maintained. The oral

route is preferable, but if not tolerated, it may be given subcutaneously or intravenously.

Its toxic effects are many. Headache, lassitude, anorexia, nausea, and even vomiting are frequent. Nearly all sulfanilamid-treated patients show some degree of cyanosis, which may be disregarded as it is not due to oxygen lack. Some authorities believe that the cyanosis is a phototropic reaction of the circulating drug to ultraviolet in the light. Others think that is due to the formation of sulfhemoglobin and methemoglobin. The above listed signs and symptoms do not call for the suspension of the drug.

The following reactions, however, do require discontinuance of sulfanilamid: Simple fever, due to sulfanilamid; dermatitis, jaundice, which may be the first sign of acute yellow atrophy of the liver; acute hemolytic anemia, agranulocytosis, and peripheral neuritis.

Because of these possible complications, a patient receiving sulfanilamid must be carefully watched, and complete blood counts should be done at least every other day in addition to the routine observations.

#### OTHER SULFONAMIDS

Sulfathiazole is an even better urinary antiseptic than sulfanilamid. The dosage is the same. It will kill the enterococcus, or streptococcus fecalis, which is not affected by sulfanilamid. Its toxic effects are less, but it can

form intra-renal depositions of crystals. If hematuria, or flank pain occurs, the drug must be stopped and fluids must be forced. In addition, the same general precautions as those used for sulfanilamid must be employed.

Sulfapyridine offers no advantage and has the definite danger of forming renal calculi.

#### NEOARSPHENAMINE

Neoarsphenamine will often eradicate coccal infections that have resisted other forms of therapy. Four to six intravenous injections of 0.5 grams each at five-day intervals will usually suffice.

#### RESISTANCE TO THERAPY

One-third of cases, as mentioned above, have some form of pathology, usually an obstructive uropathy, which prevents effective chemotherapy. These demand correction.

A safe working guide is this: Any acute case which does not give a negative Gram stain and culture after one week of therapy, demands complete urologic investigation. Recurrent cases should be urologically checked. Any chronic case resisting treatment three to four weeks should have the same complete work-up. It is only by such a study that the accessory factors, usually obstructive, can be identified and remedied. Otherwise, infection and back pressure changes persist and increase, with the eventual destruction of one or both kidneys.

31 Lincoln Park

### CANADA CONTROLS THE SALE OF PAREGORIC

The United States is consuming fifteen times as much paregoric per capita as does Canada. Canada regulates and controls the sale and use of this drug more strictly than we do. Every container of paregoric must be labeled "It is unlawful to administer this preparation to a child under two years of age, as it contains opium and is dangerous to its life." Only a physician can order *any* form of opium for a child under two years of age, and a registered pharmacist can only obtain up to 80 ounces in one month. The result is that the

annual consumption of paregoric in Canada has dropped from 8727 gallons to 700 gallons per annum. Our supply of opium is imported and must be conserved. The addict is clever and can obtain opium in this form under various names. Canada passed their control law with three aims in view: protection of the public's health, the conservation of needed drug supplies, the suppression of drug addiction. Addicts have been unable to break through this wall of national protection, and paregoric addiction is no longer a social problem in Canada. Let us end it as one in the United States.

## RECOGNITION AND MANAGEMENT OF CARDIAC NEUROSIS

By JOSEPH B. WOLFFE, M.D., Philadelphia, Pa.

Cardiac neurosis may be defined as an unwarranted haunting fear of invalidism or premature death as a result of heart disease. It may be easy enough to differentiate cardiac neurosis from true heart disease in the complete absence of cardiac dysfunction. It is far more difficult to evaluate the extent of cardiac neurosis if it is superimposed upon a heart lesion since there are no strict rules which may guide us. The greatest aids are a thorough knowledge of medicine and experience in its application. These can be acquired. True, not as easily as roentgenologic or cardiographic equipment, but once mastered are much easier to transport and apply. As a matter of fact, without personal art and skill, the use of scientific equipment may do more harm than good in cases of cardiac neurosis.

A physician can almost "sense" a neurotic pattern as soon as he sees it, but that is not enough. To manage a patient with a cardiac neurosis, one must be absolutely certain of the diagnosis and then convey that certainty to the patient.

### ETIOLOGY

Cardiac neurosis is seen most frequently in young and middle-aged women and in young men. Their tendency to dramatic exaggeration is well recognized. Pain is magnified, occurs most often at night, lasting from one-half to several hours, and is rarely related to effort. The symptom pattern is not clear-cut as compared to that seen in organic cardiovascular disease. Exaggerated heaving and sighing respirations, frequent attacks of dizziness and faintness with an ever-present shadow of anxiety seen in other types of neuroses, make up the general picture. Hereditary or congenital tendency to neurosis and prolonged and severe emotional disturbances are probably the important underlying causes of this disease. Economic or social failure, insecurity, misunderstanding of medical findings, sudden death of

a friend due to heart disease, startling press reports, endocrine disturbances, physical injury, particularly to the chest; infectious diseases, coffee and tobacco, and conscious variations in cardiac rate, force and rhythm, are probably some of the leading precipitating factors. Everything we have said so far is well known and needs no particular emphasis.

Psychic stimuli may bring about changes in cardiac rate, rhythm and force, making the heart the sounding board of emotions. And conversely, an occasional extra systole, forceful heart beat, dropped beat or other conscious functional disturbance of the heart may be relayed through the diencephalon and may set up a psychic disorder. Unfortunately, it is rarely opportune for the patient to consult a physician during these episodes. Unless the abnormal heart action occurs during the examination, which rarely happens, patients often feel that they have failed to describe adequately their experiences, and in spite of a thorough investigation by the physician, the patient is still in doubt as to whether the doctor actually knows what is wrong.

Abnormal cardiac rate, rhythm and force register and are retained in the gnostic center of the frontal lobe of the brain. This can be recalled by patients, if they try, and it can be translated with their hands into motor patterns. In this fashion they can illustrate the heart's behavior and can permit the physician to differentiate between paroxysmal tachycardia, fortocardia, extra systoles, etc. The heart, in such instances, acts as a sensory organ. The accuracy with which the patient's sensation is translated is amazing. The physician may utilize this as an aid in understanding the type of mechanism responsible for the patient's alarm.

At this time let us consider several syndromes which are included under the heading of cardiac neurosis.



## NEUROCIRCULATORY ASTHENIA

Effort syndrome,<sup>1</sup> originally described as the irritable heart of soldiers<sup>2</sup> by Meyers<sup>3</sup> and DaCosta,<sup>4</sup> is a timely subject. With war fronts at everyone's doorstep, this disturbance will be seen in civilian life even more than heretofore. The malady is characterized by a limitation of the cardiovascular capacity for effort, heart consciousness, giddiness, sweating, palpitation, dyspnea, faintness, cold perspired extremities and mainly undue fatiguability with varied degrees of anxiety. Craig and White,<sup>5</sup> in their analysis of 100 cases of neurocirculatory asthenia, found palpitation, respiratory discomfort, precordial pain and exhaustion to be the four cardinal symptoms of this syndrome. Neurocirculatory asthenia seems to be due to an abnormal response of the central nervous system to effort. These patients suffer from cardiac as well as other neuroses. Cardiovascular examination fails to reveal any abnormality in most cases. Asymptomatic organic cardiac disease may at times be discovered. This confuses the inexperienced. Patients who suffer from this syndrome have a normal pulse and respiratory rate while at rest. Minor effort or excitement brings about acceleration of the heart rate with a delayed return to preëxercise levels. The heart action often remains more forceful for some time after effort.

Strain of war and military training are contributing factors in the precipitation of effort syndrome which is a *real*, and *not* an *imaginary* incapacity. At first glance it may appear that the patient who refuses to accept the regimentation necessary in military life is a malingerer, but that is not true. "Undoubtedly the most important phase in the treatment of this condition is prevention. Prophylaxis should begin at the time of enlistment and in the training camps. The faulty examinations in the last war

are already illustrated, as pointed out by Lewis,<sup>2</sup> by the fact that nearly half of the patients invalided for effort syndrome or heart disease developed the symptoms before joining the forces and more than half developed them before their training was completed." There is not the slightest doubt, states Lewis,<sup>6</sup> that adequate examinations would have eliminated half of these men, would have kept them in useful employment, would have saved hospital space and large pension funds. We can, therefore, see how important it is to recognize this malady at this time.

## TREATMENT

The treatment of neurocirculatory asthenia is, to a large extent, the same as that of any other type of cardiac neurosis. Its early recognition and advice against sudden physical and mental strain is the keynote of therapy. In more advanced cases persuasion, reëducation and rehabilitation play a very important rôle. Injections of suprarenal cortex (Eschatin) 2 cc. daily, with a high salt diet, is a useful therapeutic agent in this disease.

## VEGETATIVE REACTIONS

Vegetative stigmatization of the cardiovascular system is responsible for several types of cardiac neurosis. Cardiac sympathetic and parasympathetic hyperirritability, although rarely seen in pure form, are frequently encountered. The underlying and precipitating causes of both are much the same. The symptoms are due to a morbid reflex arc which gains expression predominantly through the cardio-sympathetic and cardio-parasympathetic components of the autonomic nervous system.

Cardio-sympathetic hyperirritability is most frequently seen in women. These patients are subject to attacks of sinus tachycardia, the onset and termination of which are gradual. There is a great deal of fear of invalidism and death. The heart rate varies considerably in the lying and sitting positions. During the "attack" the heart rate ranges between 80 and 100 per minute. There are definite fluctuations in blood pressure. Heart beats are forceful. The inexperienced but alert physician suspects

1. Oppenheimer, B. S.; Levine, S. A.; Morison, R. A.; Rothschild, M. A.; St. Lawrence, W.; Wilson, F. N.: Report on Neurocirculatory Asthenia and Its Management. *Mil. Surgeon*, April and June, 1918, XLII, 711.

2. Lewis, Thomas: *The Soldier's Heart and the Effort Syndrome*, ed. 2. London, Shaw and Sons, 1940.

3. Meyers, A. B. R.: On the Aetiology and Prevalence of Disease of the Heart Among Soldiers. London, 1870, p. 22.

4. Da Costa, J. M.: On Irritable Heart: A Clinical Study of a Functional Cardiac Disorder and Its Consequences. *Am. J. Med. Sc.*, 1871, LXI, 17.

5. Craig, H. R., and White, P. D.: Etiology and Symptoms of Neurocirculatory Asthenia: Analysis of 100 Cases with Comments on Prognosis and Treatment. *Arch. Int. Med.*, 1934, LIII, 633.

6. Editorial, *J. A. M. A.*: August 17, 1940. 115:7, 537.

thyrotoxicosis, but the basal metabolic rate is within normal limits. Emotional shock is one of its most common precipitating factors. Digestive disturbances, flatulence, coated tongue, and atony of the gastro-intestinal tract accompany this syndrome.

#### TREATMENT

In contradistinction to neurocirculatory asthenia, these people are nearly symptom-free when physically and mentally occupied. These patients should, therefore, be encouraged to be occupied outdoors as much as possible, preferably not in direct or excessive sunlight. An alkaline-ash diet and alkalies afford symptomatic relief due to their tendency to counteract, to some degree, the action of epinephrine. Tincture of valerian, potassium bromid, aromatic spirits of ammonia, separately or in combination, are also excellent therapeutic agents for these cases. In severe instances we have found Desympatone,<sup>7</sup> which is an epinephrine neutralizing fraction obtained from the pancreas, to be of therapeutic benefit.<sup>8</sup> We administer it intramuscularly, giving 1 to 2 cc. doses every other day, and in enteric coated tablets by mouth. Tobacco in some of these cases seems to be of benefit, as much as I hesitate to make such a statement.

#### PARASYMPATHETIC IRRITABILITY

Cardio-parasympathetic hyperirritability is most frequently seen in men. Their hearts are subject to variations in cardiac rate, force and rhythm. Ectopic beats which may precipitate short attacks of paroxysmal tachycardia are not uncommon. Parasympathetic stimulation may be responsible for a tachycardia by suppressing the normal sino-auricular mode and permitting ectopic foci in the heart to assume temporary control. Precordial pain, heartburn, aerophagia, dizziness, gastro-intestinal hypermotility with symptoms suggestive of peptic ulcer or colitis and irritability of the urinary

bladder as well as peripheral vasomotor disturbances are not uncommonly met with in this group. In severe cases, faintness with sensations of heat and sweating and syncopal attacks may occur. These symptoms may at times become alarmingly severe. In the literature under "Gower's Syndrome" or "vaso-vagal attacks", we find an excellent description of what we believe to be a very severe type of cardio-parasympathetic disturbance. These patients are frequently subject to allergic phenomena.

#### TREATMENT

They respond well to a high calcium acid-ash diet, if they are kept out in the sun as much as possible, or given Quartz-lamp exposures. Graduated exercises should be encouraged. Tobacco, digitalis, eserine and cholinergic substances should be avoided. Competent eye refraction when indicated is not to be overlooked in the treatment of this disturbance. Barbiturates with belladonna given for a prolonged period of time, cod-liver oil and calcium are useful in the treatment of this condition. Calcium chlorid or calcium gluconate intravenously is indicated in very severe cases. This seems to have a two-fold effect. It may counteract allergic phenomena as well as parasympathetic overactivity. Sympathicomimetic drugs such as ephedrin or benzedrin are valuable adjuncts.

#### NOTHNAGEL'S SYNDROME

Nothnagel's syndrome is one of the less common types of cardiac neurosis, apparently due to a deranged vasomotor mechanism or thermal allergy. These patients complain of attacks of palpitation (although the heart rate rarely exceeds 100 beats per minute), coldness of the extremities, giddiness, and pain or a sensation of uneasiness over the precordium. Changes in weather seem to precipitate these attacks, particularly exposure to cold. Occasionally this syndrome occurs during outdoor bathing in cool weather. In one case we had a most encouraging result following the administration of two tablets of histaminase before meals, three times daily. In this case the patient, whose occupation required him to be out in inclement weather, was able to return to work.

7. Wolffe, Joseph B.: The Therapy of the Tissue Extract (Desympatone): Read before the 32nd Annual Meeting of the American Therapeutic Society, June 5-6, 1931, Atlantic City, N. J.

8. Wolffe, Joseph B.; Munch, James C.; Rabinowitz, Harold M.; Digilio, V. A.: Desympatone—A Fraction of Insulin—Free Pancreatic Extract. The *sechenov Journal of Physiology of the U. S. S. R.*, vol. XXI No. 5-6.

#### HYPOGONADISM

Hypogonadism is a well-recognized endocrine disturbance, yet many borderline patients, because they complain of palpitation, profuse sweating and precordial pain, masquerade as cardiac neurosis. Upon investigation one finds impairment or cessation of gonadal activity. In women past middle life, particularly with a history of partial or complete menstrual cessation, the diagnosis is obvious and the therapy is self-suggestive. Hypogonadism is also seen in men of various ages as well as in young women. In addition to the above-mentioned symptoms, these patients show marked vasomotor instability.

In the male, a feeling of exhaustion, palpitation, and precordial distress follows normal sexual relationship. We have even noticed S T segment and T wave electrocardiographic changes in some of these individuals. This disappears upon gonadal replacement therapy. Testosterone propionate — 25 mgms. — once weekly, and advice to abstain from sexual relationship for a short time, is recommended for the male. In young women, 3000 to 5000 units of estrogenic hormone given every other day for 20 days following the menstrual cycle, has given very satisfactory results.

#### GENERAL PRINCIPLES

A few general principles apply to the treatment of all forms of cardiac neurosis.

It is important that advice be given only after a careful history and physical examination have been completed.

Laboratory, x-ray and electrocardiographic

studies should be done for the sake of thoroughness; but it should be explained to the patient that these are routine measures and that they are not done because heart disease is suspected.

A candid discussion with the patient about his symptoms and unhesitating assurance that he is not suffering from heart disease is essential.

It is imperative to explain to the family that an attitude of sympathy and understanding should be established with the patient, rather than one of censure. It must be kept in mind that the patient truly suffers.

Sedatives should be used when indicated. After reassuring the patient that he has no heart disease, inclusion of digitalis in a prescription, even in the smallest dose, is enough to upset the apple-cart. The patients are extremely alert and suspicious, and because of their apprehension they study the prescriptions given to them.

Elimination of tea, coffee and alcohol in some cases deserves consideration.

While an intimate knowledge of psychology or close coöperation with a psychiatrist may be desirable, it is not always essential. If a psychiatrist coöperates in the treatment of cardiac neurosis, he should refrain from probing too deeply.

A patient and sympathetic general practitioner with a tactful approach is adequately prepared to manage the problem of cardiac neurosis. If he is not sufficiently equipped, he should consult an experienced colleague. This alone often proves to be a most valuable therapeutic agent.

1829 Pine Street

#### EGG YOLK POWDER

The feeding of egg yolk powder caused 9 of 10 patients to gain weight, whereas previous high calory diets supplemented by vitamins had failed, Alfred Steiner, M.D., reports in *The Journal of the American Medical Association*.

"Egg yolk powder is a rich source of vitamins A and D and the water-soluble fraction

of the vitamin B complex. The cost of the egg yolk powder was 15.4 cents daily, or \$1.08 a week, for each patient.

"From the data presented it would appear of value to add egg yolk powder to the list of agents used in stimulating an increase in body weight in special instances."



## WHEN ARE DUODENAL AND GASTRIC ULCERS AND GALL-BLADDER DISEASE MEDICAL AND WHEN ARE THEY SURGICAL?

By MANFRED KRAEMER, M.D., Newark, N. J.

Read at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 21, 1941.

Although generally termed "peptic ulcer", gastric ulcer and duodenal ulcer are different diseases.

Gastric ulcers should be treated *medically* unless the following complicate:

1. *Hemorrhage* uncontrolled by medical means, or repeated hemorrhage.
2. *Perforation and penetration*.
3. *Obstruction*, either at the pylorus with marked gastric distention, or in the mid-portion of the stomach with hour-glass formation.
4. *Failure to heal* promptly on *adequate* medical management.

### HEMORRHAGE

*Hemorrhage*: Blackford\* has shown that most patients who die from ulcer hemorrhage die in their first hemorrhage. Since each case must be individualized, no absolute rules can be made, but a procedure for the average case is here suggested:

Hospitalize bleeding ulcers. A red count and a hemoglobin should be performed every six hours on all cases of bleeding ulcer and blood pressure readings should be made every three hours. The first blood counts may be spuriously high due to hemoconcentration. Shock should be combated by intravenous fluids and transfusions. On admission to the hospital I give bleeding ulcer patients ascorbic acid and Hykinone parenterally. It is not necessary to continue transfusions if the red count remains over 2,000,000 and the hemoglobin over 40 per cent. If, despite repeated transfusions, the red blood count can not be maintained at 2,000,000, surgical intervention should be sought within less than 48 hours from the onset of the hemorrhage. Patients in the arterio-sclerotic age (over 45) should be operated upon with less hesitancy than those in the younger age group.

Contrary to the rule for acute appendicitis—"when in doubt, operate", for bleeding ulcer—"when in doubt, don't operate".

### PERFORATION AND PENETRATION

An acutely *perforated* ulcer should be treated surgically as soon as the diagnosis is made.

*Penetration* is the slow erosion of an ulcer through the gastric wall with concomitant inflammatory reaction at the serosa forming a seal against entrance of the gastric contents into the peritoneal cavity. Penetration may be slow, proceeding over months and years with periodic erosions and inflammatory sealings. In such a manner an ulcer may penetrate an inch or more beyond the gastric wall without causing diffuse peritonitis. A favorite site for penetration is into the pancreas. The patient may have excruciating pain, fever and leucocytosis. If perforation can be excluded, it is best to observe the patient until the inflammatory reaction subsides. The patient should be kept in bed. Morphine may be given to control pain. Acid secretion should be removed from the stomach through a Levine tube and fluids should be given intravenously. Frequent leucocyte counts and temperature readings will give a hint of the progress of the lesion. If after twelve hours there is improvement, a liquid diet may be prescribed. After three or four days the acute inflammation subsides, the blood count becomes normal and the fever vanishes. Roentgenograms may be taken to confirm diagnosis. Vitamin deficiency can be neutralized by a parenteral supply. When the patient is in the best possible state of nutrition, an elective operation can be performed without the risks attendant on emergency surgery. Of these hazards, not the least is a weary surgical and nursing staff lacking that rest so essential to speed, skill, and good judgment.

\* Blackford, J. M.: Journ. Am. Med. Assn., 115:1774, Nov. 23, 1940.

## OBSTRUCTION

Old ulcers of the mid-portion of the stomach cause an hour-glass deformity. Such cases should have a gastric resection.

Prepyloric lesions causing barium retention for 24 hours should be treated surgically. It is possible by medical means to reduce edema and diminish the amount of retention; even to "cure" the patient temporarily. Indeed after hospital treatment and its concomitant expense, the patient may feel well. A few months or a year later, he returns in worse condition than when first seen, his capital further depleted by loss of income due to illness. Operation must be performed at greater risk with reduplication of expense.

Prepyloric ulcers with gastric retention of some barium meal after six hours but no retention at twenty-four hours should be treated medically. If after four weeks of adequate medical treatment there is still some retention of barium at six hours, surgical treatment is indicated.

## FAILURE TO HEAL

All gastric ulcer patients should be hospitalized and the gastric contents kept as near neutral in reaction as possible for three to four weeks. Any of the modifications of the Sippy diet may be used, and several satisfactory antacids are available. I use magnesium trisilicate, aluminum hydroxide gel, or calcium carbonate between feedings. If symptoms persist, introduce a Levine tube into the stomach and obtain a specimen for gastric analysis. You will probably be surprised to find a high acid, which indicates the need for additional amounts of antacid or more frequent feedings. If the gastric contents are not excessively acid, look for some other cause of symptoms—gall-bladder disease, alkalosis or penetration of the ulcer. If despite half-hourly feedings and large doses of antacids neutralization is not obtained, retake roentgenograms and look for six-hour retention of barium. Such retention demands surgical intervention.

After three weeks of the outlined medical course, x-rays should be taken. Unless the ulcer niche has markedly diminished in size, gastric resection should be performed. If the

niche has disappeared or has become very small, medical treatment should be continued; but films should be taken every few months to be sure that the niche remains healed. If healing does not persist despite ambulant medical treatment, resection should be performed. If the niche stays healed for a year, x-rays should be taken annually and the patient must adhere to a modified diet permanently. Any recurrence which fails to improve on a repetition of the rigid ulcer course calls for surgery.

Even with the gastroscope we have no positive means of determining whether a gastric ulcer is malignant or benign. Malignant ulcers may decrease in size under medical management. Therefore, unless the lesion disappears and stays healed, do not hesitate to resect.

## DUODENAL ULCER

Indications for choice between medical and surgical treatment are the same for duodenal as for gastric ulcer in hemorrhage, perforation and obstruction. In chronicity the choice of treatment differs. Resection need never be performed for fear of malignancy, as duodenal ulcers are *never* malignant.

Subtotal gastric resection carries with it, in good hands, a mortality rate of only 5 per cent. Recurrence in the form of marginal ulcers may be expected in from 2 to 10 per cent of the patients on whom subtotal resection is performed. A large proportion of patients on whom gastric resection has been performed suffer permanently from periodic diarrhea and postprandial pain especially after large meals. They may suffer from bile gastritis.

Uncomplicated duodenal ulcer is a medical disease. The patient must be educated to the fact that he suffers from a chronic illness, that he must consider himself ulcerous or potentially ulcerous for the rest of his life. He must be taught permanently to avoid those tension states which are the common cause of recurrence. He must learn to live permanently on a restricted diet which need not necessarily be too uninteresting. He must be taught to avoid upper respiratory infections and grippe and to go to bed if they are acquired; to go to bed to treat his ulcer, not his grippe or sore throat. He must permanently give up smoking,

and must discontinue the use of concentrated alcoholic beverages. An occasional beer or light wine with meals is not harmful.

Patients who, despite strict observance of these regulations, do not have sustained relief after several hospital ulcer courses, should have a sub-total gastric resection.

Patients who refuse to follow the rules for living with ulcer and are willing to take the chances of surgery can also be operated upon; *caveat emptor*.

#### MARGINAL ULCERS

Marginal ulcers should be given a trial of medical management. Healing occurs in one-third of the cases. Ulcers that do not heal should be treated surgically.

Now under my care is a maitre-d'hotel who ten years ago had a pyloric obstruction due to duodenal ulcer. A gastroenterostomy was performed. Subsequently a marginal ulcer developed. The gastroenterostomy was unhitched and he was subjected to a sub-total gastric resection. Within a year, two jejunal ulcers formed. The patient was hospitalized for a few weeks and then continued under ambulant management. Thus I have been able to keep him symptom-free for the past five years.

#### GALL STONES

Gall stones are a surgical problem. We should not speak of the medical treatment of gall stones nor of innocent or harmless gall stones. Symptom-provoking or symptomless, stone-containing gall bladders should be removed. "Silent" gall stones have the habit of becoming noisy at the most inconvenient times. After coronary thrombosis, during pneumonia, after a pelvic operation, during pregnancy or whenever the health of the patient precludes immediate surgical relief, they suddenly assert themselves. What are the contraindications to the removal of the stone-containing gall-bladder? In the presence of a complicating disease, with a short life expectancy, an attempt should be made to carry the patient along medically. However, even if life expectancy is short and if that life is made miserable by repeated attacks of colic, cholecystectomy should be performed. The problem of

operation often comes up in the patient who has had a coronary occlusion or suffers from angina pectoris and has concomitant attacks of biliary colic. If the symptoms are not controlled by medical measures (or if to control symptoms the diet must be so restricted that the patient loses weight and strength), I usually put the decision up to the patient as follows: "You know you have heart disease, and having such, the risk of operation in your case is increased. Despite the condition of your heart you have a nine-out-of-ten chance of surviving an operation. We have given medical treatment a fair chance and you have not been greatly benefited. It is up to you to decide if life is worth living as you are; or if life is so miserable as to warrant taking a nine-out-of-ten chance to improve it." The patient usually requests operation. "Angina pectoris" frequently lessens after removal of a diseased gall-bladder.

In regard to cholecystectomy in the aged, I apply the same principle. If life expectancy is not too short and if symptoms are not controlled medically, I leave it to the patient to decide if the chance of relief is worth taking. Almost invariably the decision is for surgery. This winter I have had four patients in their eighth decade successfully operated upon for gall-bladder disease.

#### THE STONELESS GALL BLADDER

The diseased stoneless gall-bladder is a medical problem. Non-calculous cholecystitis is a chronic disease. This is seldom realized. As a consequence the patient is placed on a non-irritating diet, given some bile salts and a few therapeutic Lyon drainages and sent on his way. The patient must be told that he has a chronic illness, that in the presence of upper respiratory or gastrointestinal infection, symptoms are likely to recur. He should be kept under observation for life. A biliary drainage should be performed once or twice a year and a cholecystogram should be taken every two years, both to evaluate the condition of the gall-bladder and as a guide to therapy. Beware of removing a non-calculous gall-bladder, with this exception: the non-calculous gall-bladder which is functionless or which (as evidenced



by roentgenograms) fails to contract after a fatty meal and which will not yield any "B" or gall-bladder bile after a series of 8-10 weekly biliary drainages. These non-emptying gall-bladders usually have a strictured cystic duct. They should be treated surgically.

#### ACUTE CHOLECYSTITIS

I am not of the school which believes that patients with acute cholecystitis should be subject to immediate surgery like patients with acute appendicitis. Patients having acute cholecystitis should be hospitalized. All food should be withheld. Glucose in saline should be administered intravenously by continuous drip. Frequent white blood counts should be performed and rectal temperatures should be taken every four hours. The physician should palpate the abdomen several times a day. If abdominal rigidity increases, if the white blood count and temperature steadily rise, a cholecystostomy should be performed followed after an interval of a few months by a cholecystectomy. However, if the symptoms diminish, the temperature declines and the white blood count

shows subsidence of infection, the patient should be carried along until all evidence of acute inflammation disappears. Then a cholecystogram may be taken and a Lyon drainage can be performed. If stones are demonstrated or if the gall-bladder is functionless, a cholecystectomy is advised. Rarely, no stones can be demonstrated and the gall-bladder functions. These occasional patients can be treated medically.

#### SUMMARY AND CONCLUSIONS

1. Peptic ulcer primarily is treated medically. Hemorrhage, perforation, penetration, obstruction, and chronicity may indicate surgery.
2. The stoneless diseased gall-bladder which functions or can be made to function should be treated medically.
3. Gall-bladders containing stones and those without stones which cannot be made to function should be removed.
4. Acute cholecystitis should be treated medically unless inflammation fails to subside under medical management.

31 Lincoln Park

## SULFONAMID SUPPOSITORY IN THE TREATMENT OF ACUTE GONORRHEA IN WOMEN

Twenty-five cases of acute gonorrhea in women were treated by the oral administration of sulfonamid, 80 gr. daily for the first three days, and 60 gr. thereafter for two weeks. It could not be concluded from the results in this series that sulfonamid administered orally, in the absence of other treatment, was a satisfactory means of treating gonorrhea in women.

The sulfonamid then was incorporated in a boroglyceride base, using 20 gr. of sulfonamid and 10 gr. of lactose in the suppository. Twenty-five patients suffering from acute gonorrhea were treated by the insertion of one sulfonamid suppository high into the vaginal vault three times a day. These patients were treated for 17 days. It was noted that the symptoms of dysuria and purulent leucorrhea disappeared in 12 of the patients on the third day. Smears from the urethra and cervix were

negative in all 25 patients at the end of one week. It was possible to follow 21 of the 25 for a period of three months. Nineteen patients were symptom-free without evidence of urethritis, and there were no cases of Bartholinitis. There was not a single case of salpingitis. One patient, at three months, had an acute gonorrhea which could be traced to an intercourse five days previously. One patient had a residual endocervicitis. The most remarkable feature of these 19 cases was the absence of any endocervical infection, this being confirmed by the absence of pus cells in the cervical smears.

It is suggested that sulfonamid locally in the form of boroglyceride suppository probably has real value in the prevention of complications and cure of infection.—William Bickers, M.D., *Am. J. Obst. & Gyn.*, 1941. (Clinical Abstracts.)

## DESCENT AND PROLAPSE OF THE UTERUS AND VAGINA

By ARTHUR J. WALSCHEID, M.D., Union City, N. J.

The cause of prolapse of the vagina and the uterus cannot be described in a few words. The teaching has long been that relaxation of the uterine ligaments and their allied structures is the most important cause of prolapse. I believe, however, that prolapse of the uterus begins only when a primary muscular insufficiency of the pelvic floor allows the upper supporting structures to descend. It is also my opinion that prolapse of the vagina and the uterus cannot occur until a hernia of either the anterior vaginal wall, posterior vaginal wall, or both is developed at the genital hiatus. Before the hernia can arise, there must be primary relaxation, loss of tone, or laceration of the pelvic floor. The other etiologic factor is chiefly loss of the integrity of the endo-pelvic fascia as it is anatomically dissectable in the pararectal, paravesical, parauterine and paravaginal endo-pelvic spaces.

### ANATOMY

The endo-pelvic fascia is entirely separate from the true fascia which so closely covers all the genital organs and the bladder. The integrity of the pelvic floor and endo-pelvic fascia is most important to the prevention of uterine prolapse but structures should not be considered as a separate unit from the true organic fascia and uterine ligaments. The uterus, its ligaments, and the underlying pelvic connective tissue must be anatomically visualized as an inseparable unit, particularly in their supportive action of the pelvic organs and tissues. These structures are so closely allied to each other that loss of innervation, injury, loss of tone or laceration of any one must necessarily affect the entire supporting structure.

Constitutional type habitus and soma are other factors in prolapse. Hypodevelopment of the uterus, its ligaments, surrounding connective tissues, and muscular support, presents an anatomic form predisposed to prolapse, general structural deficiency and loss of tissue tone. Such types invariably begin with primary retroversion, retroflexion and procidentia

uteri. Prolapse of the uterus occurs after intraabdominal pressure persistently bears its directive force upon the uterine wall, toward and parallel with the longitudinal axis of the vagina; its force increasing downward and not meeting with any resistance at the hypoplastic toneless pelvic floor. Anomally, hypoplasia, etc., of this type is predilective to virginal prolapse.

### MECHANICAL FACTORS

Post-parturient prolapse occurs when the supportive connective tissue of the uterus, the vaginal wall, and pelvic floor have been sufficiently injured by trauma, followed by a hernia of the vaginal wall. The vaginal and bladder walls are so closely connected and bound together by a dense connective tissue that prolapse of the anterior vaginal wall always coexists with a cystocele, although cystocele or rectocele without prolapse of the uterus is frequently seen. One or both are caused by laceration of the paravesico-endopelvic, rectal, para-rectal and posterior vaginal wall fascia, and a supporting pelvic floor. A primary uterine prolapse may cause a cystocele, and a primary cystocele may produce a secondary prolapse. Loss of tone of the ligament Mackenrodt, plus injury to the pelvic floor support is present in the first instance, while in the second the anterior vaginal wall has been injured before prolapse can occur. The rectal wall frequently remains in place in early stages of prolapse of the posterior vaginal wall because recto-vaginal connective tissue is less densely attached to the rectum than to the anterior wall of the bladder. Anomaly, defect and injury of the pelvic floor always predisposes to loss of tone and insufficiency of tissue elasticity.

One of the causes of paralysis of the muscles of the pelvic floor is occulta-spinabifida. Another is disease of the spinal nerves. In spinabifida-occulta, insufficient enervation to the pelvic floor, weakness of muscular contraction and loss of tone finally lead to uterine descent. In every virginal prolapse, an x-ray of

the lower spine should be taken. A lumbar-sacral indentation or a clump of hair may indicate presence of an underlying anomaly.

Abnormal constitutional habitus influences prolapse, especially after long and delayed labor or operative delivery followed by postpartum loss of muscle tone from a lacerated pelvic floor, improperly repaired or not repaired at all. Involution of the uterus, the abdominal muscles and pelvic floor is frequently the cause of prolapse of the vaginal walls and the uterus.

Every incidence of procidentia, no matter how slight, co-existing with uterine retroflexion has all the mechanical potentialities of a progressive prolapsed uterus and prolapsed vaginal wall or walls. Early prolapse without complications can be cured by a simple operation which prevents the occurrence of a progressive pathologic condition which would demand more complicated surgical intervention. The clinical examination of every case of uterine prolapse first establishes the degree, condition of anterior and posterior vaginal wall, position of the uterus, extent of bulging or gliding of the bladder or rectal wall, presence and caliber of vaginal gaping and urinary control of incontinence, frequency or retention.

#### URINARY INCONTINENCE

The most important early clinical complication of prolapse is urinary incontinence due to increased intraabdominal pressure on the bladder. Incontinence occurs during the act of coughing, straining at stool or lifting. Urinary retention is usually present in cases of large cystocele. In prolapse, there is frequently found residual urine and painful cystitis. A urinalysis is always indicated. Failure to recognize complications arising from descent of the vaginal wall or walls is the most frequent cause of diagnostic error and therapeutic failure. Another complication is pressure sores causing marked swelling and congestion of the prolapsed tissue from exposure, pressure constriction, and friction irritation. Localized edema may be so extensive that the enlarged prolapsed tissue and uterus cannot be replaced until palliative treatment has reduced its size. It is

poor surgery to operate so long as the vaginal mucosa is excoriated, edematous or infected.

#### BACKACHE

Backache should not be considered a symptom of prolapse. It is caused by the co-existing lordosis and pendulant abdomen from postural strain to the erector spinae muscles. Palpation demonstrates either one or both of these muscles as spastic and firm. A focal infection such as superimposed infected sinus, teeth, tonsils and flat feet, collectively or alone, should be considered where lordosis is absent. Lordosis is never absent in prolapse, and in its absence the presence of a true prolapse can safely be doubted. A virgin or multipara is the exception to this rule.

#### DIAGNOSIS

The symptoms which bring the patient to the gynecologist are vaginal pressure and feeling of weight and heaviness in the vagina. The severity of the symptoms varies with the degree of the prolapse.

A cystocele appearing at the hiatus under voluntary abdominal pressure is easy to diagnose, but a prolapse of the uterus during its early development is more difficult to recognize because it does not always cause subjective pressure symptoms. Cystitis and pyelitis should be determined.

In true prolapse, retroversion and procidentia usually co-exist. It is very difficult to tenaculize a uterus with downward traction unless anatomic changes are present and the pelvic fascia has become relaxed. The degree of every prolapse can always be gauged by the limit to which the uterus can be tenaculized.

Early prolapse is frequently found with an apparently good pelvic floor. This does not always require operation but responds to levator ani muscle massage and sinusoidal treatment. The abdominal muscles should also be treated by electrical contractile stimulation through the tenth, eleventh, twelfth intercostal nerves, to reestablish the line of gravity and return the intraabdominal pressure to normal.

#### THE PESSARY

Orthopedic appliances are only palliative, yet the pessary is still used. Its disadvantages are:



(1) It acts as a vaginal foreign body; (2) if too small, it will fall out; (3) if too large it will interfere with coitus and cause excoriation of the vaginal wall; (4) it requires monthly visits immediately after each menstrual period for removal and replacement; (5) there is constant danger from local pressure, sores, and ulceration of the vaginal walls; and (6) pessaries will never cure a prolapse.

I have found a pessary satisfactory only for early post-natal, retro-displaced, subinvoluting uterus until the involution is completed. An improperly fitting pessary can do more harm than good. When a pessary must be used to satisfy the patient, the soft rubber inflated doughnut type which causes little if any pressure is used. The cup and belt pessary is to be condemned because of its frictional trauma to soft tissues. A ring pessary may become deeply imbedded in the vaginal wall making removal very difficult. On one occasion I had to remove a pessary with a Gigli saw.

#### SURGICAL PRINCIPLES

The operation for prolapse is always selective, but the type of operation to be performed varies with the extent, duration and degree of prolapse, the position of uterus, length of the cervix, and the presence of cystocele or rectocele.

The three-layered suture closes the anterior vaginal wall more firmly and securely than more simple methods of single layer and purse-string suture. The paravesicle fascia is difficult to free, but sufficient denudation can always be done to apply either purse-string or interrupted sutures. Post-operative cystitis usually remains for a number of weeks, but is not alarming. As soon as the bladder has functionally adjusted itself, all urinary symptoms disappear. Direct suturing of the bladder sphincter is always indicated when the bladder is incontinent.

Every case of frank, complete prolapse demands the most extensive anterior and posterior vaginal tissue dissection, resection and layer suture. The larger the prolapse the more careful the denudation. Dissection should avoid the "knee of the ureters" which are abnormally lengthened in prolapse.

Contra-indications for operation are compli-

cations of disease of liver, heart, lungs, or diseases of metabolism. A pessary should be prescribed in these cases. Under all normal conditions, age itself is no contra-indication, but selection of anesthesia demands far more thought than the operation.

#### CYSTOCELE

In marked cystocele, the bladder should be handled gently before and while pulling the prolapse down to avoid injury. In exceptionally large cystocele, the cervix usually is very much elongated while the body of the uterus is small and firmly fixed in the true pelvis. Too much traction should not be placed on an elongated cervix. The bladder sometimes is lodged and incarcerated in the posterior cul-de-sac.

A prolapse should not be replaced unless it has been definitely established that the bladder is entirely empty and it is certain that the bladder is neither held firmly nor incarcerated anteriorly or posteriorly.

In every case of prolapse, with or without a cystocele, the following should be elicited:

1. Frequency of urination.
2. Incontinence.
3. Retention.

In cystocele, the urethral canal curve is directed convexly downward. In simple urethrocele, the urethral canal is directed straight downward. When a catheter is inserted care should be taken not to make a false passage. The urethra is always elongated and curved in prolapse. A cystocele is designated by frequency in urination, a urethrocele by incontinence of urine. Each condition requires separate operative technique.

#### RECTOCELE

In the presence of a large rectocele, with or without prolapse of the uterus, always examine for an enterocele. The intestine, as a true hernia, may be found lying in the distended and pouched cul-de-sac, the latter extending from behind the uterus and appearing at the hiatus, budging between the posterior vaginal wall and anterior wall of the rectum. Rectocele is always very extensive when complicated by an enterocele. Diagnosis of enterocele is made

by: palpation, percussion, and auscultation. Palpation elicits gurgling; percussion, tympany, and auscultation, auditory borborygmus.

In a rectocele, the anterior rectal wall lies above, over and below the anterior, posterior and inferior surface of the sphincter ani and within the prolapsed pouch of the posterior vaginal wall. To demonstrate a rectocele, the index finger is hooked into the rectum over the sphincter, and the prolapsed recto-vaginal pouch is entered. This manipulation shows the extent and size of the rectocele. By a voluntary levator ani and sphincter ani muscle contraction, the patient is able to contract the pelvic floor and demonstrate the extent of loss of levator ani tone. The posterior vaginal pouch of a rectocele not infrequently is found impacted with feces, producing a coprostasis. A lower bowel irrigation with a pint of 25 per cent peroxide solution followed by a soap solution usually empties the rectum. This should be done two days before and again the morning before operation. Where proctitis is suspected, a proctoscopic examination should be made. If infection is present, the operation should be postponed until it is cleared up entirely.

#### THE OPERATION

To perform an antomic vaginal plastic operation, all of the fascial layers and muscular structures must be dissected free and sutured separately in their respective layers. Merely suturing the levator ani is insufficient. Neither the figure eight nor any mass catgut or wire should be used.

*A correctly selected operation* always predicates the best and most curative end result. *A poorly selected operation*, in the majority of instances, is soon followed by a recurrence of the prolapse. Every operation should, therefore, be specifically selected according to the complication co-existing with each prolapse. Vaginal interposition of the uterus should not be done arbitrarily for every case as an adapted routine any more than the indirect abdomino-vaginal method should be used in every case of prolapse.

The objective in every prolapse operation is:

1. Closure of the vaginal canal to sufficient

caliber to prevent recurrence of prolapse of the vaginal walls, and pelvic floor.

2. Reconstruction and suture of the vaginal wall, the endopelvic fascial and pelvic floor to give support to the prolapsed uterus from below and prevent it from becoming retroverted.

3. Secure placement of the uterus in anteversion.

These desiderata may be achieved by:

1. Amputation of the elongated cervix.
2. Repair of the pelvic floor.
3. Repair of the anterior vaginal wall, cystocele, rectocele and urethrocele. (Mucosal and fascial coaptation.)
4. Support by proper corset to elevate the anterior abdominal wall and so control intra-abdominal pressure and to maintain continuously its directive force upon the posterior wall of the uterus.
5. A study of the constitutional type, habitus, structure and biologic process of the patient, who usually has avitaminosis requiring a high vitamin and high caloric diet, general hygienic and tonic treatment.

An anteverted uterus with prolapse and cystocele is usually seen in the first degree prolapse.

Rectocele is usually seen with a retroversion.

A cystocele and retroversion are most frequently seen in the second and third degree of uterine prolapse. In a third degree prolapse both vaginal walls are usually prolapsed with the uterus. In third degree prolapse with cystocele the uterus is always in the pelvis with an elongated cervix and a large cystocele.

In the early stages of prolapse, the uterus is always anteverted, even if both vaginal walls are prolapsed. If both walls simultaneously prolapse, which is infrequent, the uterus progressively goes through the four degrees of retroversion until, finally, it lies in the prolapsed vaginal pouch in a complete retroversion. The uterus in these conditions is small and the cervix not extremely elongated.

#### AMPUTATION OF THE CERVIX

When the uterus is only partly anteverted or entering the first degree of retroversion, amputation of the cervix is advisable, done by

the enucleation method. This shortens the transverse diameter of the posterior vaginal wall as well as that of the cul-de-sac, elevates and fixes the lower third and posterior part of the uterus higher into the pouch of Douglas and the pelvis, and throws the fundus forward to place the longitudinal uterine axis at a right angle to the longitudinal axis of the vagina.

#### ENUCLEATION OF THE CERVIX

Enucleation of the cervix is done by incising a one-half inch V-shaped cervical wedge out of the posterior cervical lip, dissecting the posterior vaginal wall, the V-shaped cervical wedge still attached to the cul-de-sac mucosa and then downward, leaving the distal end of the vaginal wall flap attached to the vagina, to be used later for traction while dissecting the posterior wall further around. Cervico-vaginal mucosa is then undermined with curved scissors from behind, anteriorly, and around the cervix, freeing the entire vaginal mucosa until the mucosal cervical closure is made by proper suturing. It is then enucleated and amputated. The previously dissected attached posterior vaginal wall including its attached proximal, posterior cervical stump can be still further dissected downward to close the posterior vaginal wall to correct a rectocele, or close the vagina entirely. During this maneuver, the posterior vaginal mucosal flap is used as a tractor. Dissection from the cul-de-sac to the perineum can be carried on with ease.

After vaginal mucosa is sutured, the transverse diameter of the cul-de-sac and the posterior vaginal wall are very much shortened while the body of the uterus is tipped forward in the anteverted position. During this operation the posterior vaginal wall can be sutured to any desired dimension. The operation is completed by anterior vaginal wall denudation, dissection and layer suture of the paravesical and vaginal fascial layers, and a high suture fixation of the bladder upon the anterior wall of the uterus. High bladder fixation helps to retain the uterus in anteversion so that a permanent intraabdominal pressure is continuously exerted upon the posterior uterine wall. If the uterus is retroverted, the only operation I advocate is the interposition operation as first

done by Wertheim followed by Schauta and modified by Watkins.

#### UTERINE SUSPENSION

The operation for prolapse of uterus is either vaginal or abdominal. I prefer the vaginal or direct route except during the child-bearing period, when an abdominal Mayo-Montgomery-Simpson type suspension and vaginal plastic operation is best. A suspension should never be done without doing an anterior and posterior vaginal plastic operation at the same time. Failure to do this is a gross gynecologic error.

Uterine suspension offers the best result only if the pendulant abdomen is not too extensive: it allows for a full-term pregnancy with normal labor and birth. A high bladder fixation operation usually causes labor complications. In the presence of a pendulant abdomen, I prefer the Kelly type uterine fixation operations.

When doing a suspension, the round ligaments are brought bilaterally through the internal inguinal rings, the transmuscular intra- and ante-fascial tissue suturing them at their distal ends over both rectus and fascial muscles, as first described by Mayo and modified by Simpson. Fixation of the uterus in these cases is poor surgery. Although the Baldy-Webster throws the uterus forward, it does not elevate the base of the broad ligament sufficiently to keep the uterus properly anteverted and continuously maintain a normal intraabdominal pressure force.

In elderly women, a vaginal hysterectomy is performed with complete closure of the vagina, by the LaForte method.

#### CONCLUSIONS

Prolapse is a vaginal and pelvic floor hernia.

Protrusion of the uterus is always associated with cystocele or rectocele, alone or together; cystocele occurring alone is more frequent.

Every prolapse begins as a procidentia. Each case should be diagnosed early and operated upon as soon as the diagnosis is made, or the condition will develop into a more advanced prolapse.

The younger the patient, the more conservative the operation should be. In aged or elderly



patients, a vaginal hysterectomy and complete closure of the vagina by any of the various methods, offers the best result. Age itself is no contra-indication. The operation can be done under local anesthesia.

The cervix should be amputated in every case of prolapse, unless vaginal hysterectomy is anticipated.

The essentials to successful prolapse of uterus operations are:

1. Selection of operation considering the patient's local anatomic changes produced by the prolapse.

2. Careful dissection of muscle, fascial and endopelvic layers.

3. Anatomic replacement of the uterus and return of intraabdominal mechanical and dynamic forces where nature intended them to be, keeping the uterus in its so-called normal position.

4. Interposition operation when the uterus is retroverted but *never* when it is anteverted.

Prolapse is primarily and essentially brought about by relaxation of the elastic elements of the supportive and fixation apparatus of the genital organs.

The most prominent inciting factor in the development of prolapse is abnormally directed and abnormally increased intraabdominal pressure.

The predisposing factor of prolapse is loss of elastic tone of the supportive ligaments, fascia, and the fixation apparatus of the pelvic floor and the vaginal wall, plus the endopelvic fascia.

If a toneless uterus and relaxed retinaculum uteri descends into a procidentia, it eventually becomes retroverted because the normal intraabdominal forces exert a permanent pressure upon the anterior wall of the uterus and keep it in a retroverted position, finally stretching the elastic connective tissue elements of the pelvic floor and causing the uterus and vaginal wall to descend into a primary latent prolapse which is eventually followed by an active prolapse. The loss of elastic tissue tone in every case of prolapse is irreparable and can only be permanently repaired by operation.

Avoiding possibility of a recurrence of prolapse by making a correct diagnosis and selecting the proper operation is the important problem in every case of prolapse.

404 38th Street

## ERGOT IN THYROTOXICOSIS

One of the most distressing phenomena in the surgical management of thyrotoxicosis is the associated tachycardia. In an effort to minimize this reaction the following rationale was evolved which led to the use of ergotoxine and ergotamine in cases of thyroidectomies for thyrotoxicosis:

In the surgical treatment of thyrotoxicosis there are two periods during which tachycardia becomes a most serious and alarming manifestation: (1) During operation. (2) Twenty-four to 72 hours postoperatively—the period of so-called crises. The tachycardia occurring during operation would seem best explained by an increased output of adrenalin as a result of the subjective sensations of anxiety, fear, etc., and those objective considerations of trauma, blood loss, anoxia, etc. On the other hand, the

tachycardia occurring during the crises might very properly be explained upon the basis of a thyroxin effect because of its operative release 24 to 72 hours previously. Therefore, in the operative reaction, adrenalin is a major factor and thyroxin a minor one, while in the crises, thyroxin is the major factor and adrenalin the minor one. Ergot preparations have the quality of preventing the action of adrenalin. Accordingly, the operative tachycardia should be susceptible to control by ergotoxine and ergotamine. Clinical experience with 15 consecutive cases of thyrotoxicosis substantiates this view. It is concluded that the ergot alkaloids, ergotoxine and ergotamine are definitely useful adjuncts to the surgical management of thyrotoxicosis.—D. E. Brace and L. C. Reid, Ann. Surg. (Clin. Abst., 1941.)

THE CESAREAN OPERATION AND THE NEW JERSEY MATERNAL  
WELFARE REPORT

MATERNAL WELFARE ARTICLE NUMBER SIXTY-NINE

By ROBERT A. MACKENZIE, M.D., F.A.C.S., Asbury Park, N. J.

As a part of its function, the Maternal Welfare Committee of The Medical Society of New Jersey distributes annually to each institution caring for maternity patients a questionnaire for reporting the year's obstetrical work. Replies to this questionnaire furnish much valuable information and indicate not infrequently the weaknesses in our maternal welfare program, as well as the lack of coöperation in some counties with the plans and advice of the Committee. Each year there is an increasing percentage of women who seek the supposed advantages of hospitals or nursing homes for their confinement. Eighty-five per cent of all deliveries in New Jersey last year were in these hospitals or nursing homes. It is important that the principles of conservative obstetrics are observed and that in every respect these patients are safeguarded in these hospitals at least as well as would be the case in their homes. There are 126 institutions in New Jersey which admit and care for obstetrical patients. For 1939 ninety-one of these returned fairly satisfactory replies to the questionnaire. For 1940 ninety-nine institutions presented the desired statistical data summarizing their obstetrical work. Because most of the instances of failure to reply were by very small establishments it is estimated that 98 per cent of all the hospital maternity work in the State is thus available for survey.

This presentation considers the situation as regards Cesarean operations revealed by these reports.

There were three additional deaths following Cesareans in hospitals which did not report.

In the hospitals reporting there were a total of 119 maternal deaths in 1939 and 102 in 1940. Deaths caused by abortion and tubal pregnancy are not included in these figures. It will be seen that fatalities in cases delivered by Cesarean operation furnished approximately one-third of these totals. Although the operative mortality for the State is not very high (2.8 per cent), the Maternal Welfare Committee believes that there can be further improvement in our New Jersey obstetrics, in the employment of the Cesarean operation particularly, and that with this improvement a sharp drop in the maternal mortality rate will be accomplished.

To illustrate the distribution of Cesareans and fatalities attending or following upon this operation the figures for 1940 have been broken down and Table II shows the reporting hospitals grouped according to number of patients delivered. The incidence of Cesarean operation is highest in the very small hospitals and this is possibly explained by the fact that in rural counties home obstetrics is the rule except in event of complications. The higher death rate in the institutions with less than 500 annual deliveries may be significant but it must be realized that not all Cesarean deaths are preventable, and furthermore, in small hospitals only statistics over a period of years offer a true evaluation of work done.

Comparison of the individual hospital reports shows considerable variation in the incidence of use of the Cesarean operation. Illustrative are those given in Table III.

The two large hospitals named have proven records of conservative and conscientious obstetrics. Results would seem equally satisfac-

TABLE I

	1939	1940
Number of Patients Delivered in Reporting Hospitals . . . . .	44,760	48,649
Cesareans . . . . .	1,174	1,251
Per Cent of Cesarean Operation . .	2.6	2.57
Deaths Following Cesareans . . .	35	34
Mortality . . . . .	3.0	2.7
Fetal Loss . . . . .	61	98

TABLE II

Hospitals Reporting Deliveries	Number	Total Patients		Cesareans	Per Cent	Deaths
		Delivered				
Over 2000 .....	1	5,355		196	3.7	1
1500-2000 .....	3	5,033		146	2.8	4
1000-1500 .....	12	13,409		294	2.1	8
500-1000 .....	22	15,082		332	2.1	8
250-500 .....	17	6,075		165	2.6	8
100-250 .....	15	2,670		78	2.8	4
25-100 .....	14	781		39	5.0	1
Under 25 .....	15	246		1	0.4	0

TABLE III

	PATIENTS DELIVERED		CESAREANS		PER CENT	
	1939	1940	1939	1940	1939	1940
Orange Memorial .....	1,090	1,247	11	18	1.0	1.4
Cooper (Camden) .....	1,503	1,543	73	69	5.0	4.5
Hospital No. 1 .....	306	340	7	3	2.2	0.9
Hospital No. 2 (same rural county) .....	322	336	26	31*	8.0	9.0
Private Hospital (Urban) .....	78	57	19	9	24.0	16.0

\* One death.

tory in these two instances. In one southern county there is striking contrast in the frequency of resort to Cesarean in two hospitals of equal size. Only one fatality occurred in the hospital with a 9 per cent incidence of operation but the record is not admirable. Where separate statistics for ward and private patients are available it is everywhere seen that the frequency of operation is much higher in the private patient group. There are many and worthy reasons for this—notably the higher proportion of primigravidae and the later age at which child-bearing is undertaken. But the consistent and amazingly high percentage of Cesarean delivery in the privately owned city hospital attests a dangerously radical attitude on the part of the operators.

In only a few instances were indications for operation clearly remarked by the reporting hospitals. Many hospitals omitted entirely the reasons for the Cesareans performed. Listing of indications was haphazard and several unusual causes for operation were noted, among these being “infantile pelvis”, “anemia—to lessen shock”, “gall-bladder symptoms”, “pa-

tient overdue”, “twins”. Much duplication appeared in the use of such terms as contracted pelvis, pelvic deformity, dystocia, arrested progress, large baby, etc. Perusal of many published papers on Cesarean section shows the same confusion and repetition in listing indications for operation. A table for convenience in recording indications will be suggested later in this presentation.

Operative methods as revealed by this study are of interest but of doubtful value. Data concerning morbidity, discomfort following operation, length of hospital stay, etc., is not available.

TABLE IV  
TYPE OF OPERATION

	1939	1940
Classical .....	550	625
Low-flap .....	471	518
Others .....	63	76
Not Stated .....	91	32

In a city with two hospitals of nearly equal size, 121 out of 144 Cesareans in one hospital were performed by the low flap technique while the other preferred the classical operation in



92 of 97 cases. It may be seen that the trend in New Jersey as throughout the nation is toward the lower segment single flap procedure. Study of the detailed reports in fatal cases for this two-year period reveals the overconfidence of operators in transperitoneal intervention in dystocia cases with long ruptured membranes. It is encouraging to note that in 1940 twelve extra peritoneal Cesareans were done in hospitals throughout the state. A much larger number of extraperitoneal cases were reported, of course, in both years by the Margaret Hague Maternity Hospital, where much pioneering in this field has been done.

It is always a painful duty to review maternal deaths and read the story of tragic failure. It is difficult to select the major cause of death in cases which are complex and with information not adequately detailed. But such a selection is here attempted.

Causes of death attending or following Cesarean operation in 69 reported cases:

TABLE V

Sepsis (peritonitis, etc.)	22
Operative Shock	11
Eclampsia	10
Embolism	4
Abruptio placenta	4
Placenta previa	3
Hemorrhage—immediate postoperative	3
Pneumonia (postoperative)	1
Ovarian cyst obstructing labor (Cesarean and oophorectomy)	1
Hemolytic anemia following transfusion	1
Cardiac failure	1
Tuberculosis	1
Diabetes	1
Spinal Anaesthesia	2
Nephritis—Anuria postoperative	1
Atelectasis of both lungs (autopsy)	1
Undetermined	2

Censure of our fellow workers is not the part or pretense of the Maternal Welfare Committee. It may be fairly stated, however, that the majority of the sixty-nine mothers who died could have been saved. The fault in some instances may have been the patient's. The outcome was obviously fateful in others. But operation was not timely in many cases nor was the indication proper in all. Certainly the selection of operative technique was poor in many cases. Evidence is unmistakable that the "consultation rules" long advocated and publi-

cized by this Committee for complicated cases have been neglected in numerous hospitals.

Having in mind the findings of the study here briefly reported, the writer attempts to summarize what may be considered standard principles and practice applicable to the Cesarean problem.

INDICATIONS

Feto-pelvic disproportion is the most frequent indication for the Cesarean operation. With vertex presentations, dystocia is usually suggested by failure of the fetal head to descend into the true pelvis before or early in labor. Special roentgenographic examination is helpful but can never replace sound clinical judgment. In some cases of borderline cephalopelvic disproportion, the decision can be well made at time of beginning labor when presentation of the fetus, the condition of cervix and membranes, and the vigor of uterine contractions are known. A moderate trial of labor is desirable in most instances where cephalopelvic disproportion is the only condition which points to Cesarean as a possible or probable means of delivery. It can certainly do no harm. Mild and irregular contractions which often precede labor should not be included in hours of test. No fixed rules can be established as to how many hours constitute a good trial. Rupture of the membranes makes for a better or more certain test of progress toward delivery through the natural passages but dictates special care to avoid contamination and an early decision if a transperitoneal operation is to be done. With breech presentations, disproportion is more difficult to detect and certainly more serious since it cannot be overcome by molding in the course of labor. X-ray is of no aid in measurement of the fetal head in the fundus but lateral views of the pelvis are particularly desirable in every breech case to demonstrate the shape of the sacrum and the inclination of the symphysis. It must be remembered that there is no such thing as a trial labor with a breech presentation. In a primigravida with a large baby presenting the breech, Cesarean is the conservative procedure.

Preëclampsia is an increasingly frequent

cause for Cesarean delivery both in true toxemia and in those cases of peripheral vascular disease and chronic nephritis where pregnancy is a complication rather than a cause. The difficulties of inducing premature labor and the hazards of labor for the immature child contribute to the choice of this course. The main reason is the great advantage of terminating the pregnancy with dispatch at the time when failure of kidney function or convulsive explosion is imminent. The onset of eclampsia should rule out Cesarean operation.

Antepartum hemorrhage seems more and more to justify intervention by hysterotomy. Diagnosis of the site of placental implantation cannot always be determined. When placenta previa can be excluded conservative management of abruptio placentae in the multiparous woman may be advantageous. But even slight separation of the normally implanted placenta in primigravidae before labor is best handled by prompt Cesarean. Certainly many babies are saved in this way. In placenta previa of any type operation should not be delayed after the diagnosis is established.

Tumors, either of uterine or ovarian origin, obstructing the pelvis dictate prompt intervention by abdominal section.

Previous gynecologic operation, especially operative repair of the cervix, selected cases of heart disease and other unusual conditions make abdominal section occasionally necessary.

The objective of tubal ligation or other steps to prevent future pregnancy is never a justification for Cesarean. Nor should the insistence or desire of the patient influence judgment.

Previous Cesarean section without post-operative morbidity does not of itself necessitate secondary operation. Re-operation is only indicated where the original cause for interference obtains again, or where circumstances point to imperfect healing and threatened uterine wound rupture.

The decision in each individual case naturally depends upon many considerations, the age of the patient and length of infertility for example, in addition to the actual obstetrical problem. All the facts in the case are weighed with the goal of safety for the mother and infant equally in mind. Fortunately there is

no instance where we have to choose between these aims. The conscientious judgment of more than one physician is desirable. Consultation from the obstetrical viewpoint is preferable to the opinion of a doctor whose training is primarily in surgery.

#### INDICATIONS FOR CESAREAN

##### *Suggested Tabulation for Annual Report*

#### PRIMARY

- Cephalo-pelvic disproportion
- A. Faulty pelvic architecture
  - Elective
  - Trial labor
- B. Normal pelvis
  - (Baby over eight pounds)
  - Elective
  - Trial labor
- Feto-pelvic disproportion
  - (Breech presentation)
- Preëclampsia
  - Including chronic nephritis and hypertension due to peripheral vascular disease
- Placenta previa
- Abruptio placentae
- Cardiac condition
- Tumors obstructing the pelvis
- Previous gynecologic operation
- Miscellaneous

#### SECONDARY

- Previous Cesarean
- Age of patient
- Premature rupture of membranes with spastic retraction of the uterus (cervical dystocia)
- Previous difficult labor with stillbirth
- Others

#### METHOD

The advantages of one technique over another in elective Cesarean will never be established to the agreement of all. After a trial of labor with the lower uterine segment retracted the low-flap operation with transverse or vertical hysterotomy incision has great advantages. With a longer unsuccessful trial of labor and membranes ruptured more than twelve hours, the extraperitoneal technique is the only safe procedure regardless of the number of examinations.

Space does not permit discussion of pre-operative treatment or choice of anaesthesia. Both are exceedingly important in contributing to successful outcome and smooth convalescence. Pre-anaesthetic sedation must be given with the effect upon the baby's respiratory center in mind. Spinal or Cyclopropane anaesthetics provide ideal conditions for the mother and give the infant every chance to do well.

## BY WHOM SHOULD CESAREANS BE DONE?

This is a special operation presenting more problems, especially in secondary cases, than is frequently realized. Ideally the obstetrical surgeon is the man for the job. Extensive obstetrical experience plus sound surgical training and skill combine to equip the operator to accomplish best results. An able assistant to form a smoothly working team is a great asset. The general surgeon performing half a dozen Cesareans a year and acquainted with only the classical technique might well relinquish his privilege in these cases—or at least pass on the responsibility in complicated or “neglected” cases when it is possible to do so.

In many of our small hospitals throughout the State the number of Cesareans is too few, of course, to permit development of an obstetrical surgeon. Much, however, can be done by coöperation between the surgical and obstetrical departments of the smaller general hospitals.

In every hospital the matter of Cesarean operations can be reviewed with interest and profit. In a number of hospitals one regular meeting of the Staff is given over to a review of Cesarean deliveries for the preceding year. Following statistical and individual case reports the whole matter of indications, procedure, results, etc., is discussed. Every hospital can adopt this practice with benefit.

501 Grand Avenue

## A LESSON FROM A DEATH CERTIFICATE

### NUMBER FORTY

Patient admitted to hospital with a history of vaginal bleeding for four days after having skipped one period. Impression, ectopic or threatened abortion. Treated expectantly for four days. No vaginal examination was made. Lower abdominal pain from time to time. Sud-

denly became worse and was operated on. Died on table. Diagnosis: Rupture ectopic.

Would not a vaginal examination have helped in making an earlier diagnosis?

A. W. BINGHAM, M.D.

## MYOMECTOMY DURING PREGNANCY

Fibroid tumors of the uterus usually have no harmful effect on a coexisting pregnancy. However, the patient should be kept under careful observation for complications such as miscarriage or premature labor, obstruction to the descent of the presenting part and degeneration of the fibroid. So-called “red degeneration” of the tumor is the type usually found, and it occurs most frequently during the puerperium, probably because involution disturbs its blood supply. Degeneration may also occur during the prenatal period. Its onset is always

marked by pain, occasionally accompanied by fever and leukocytosis. When the degeneration is slight, the symptoms may be relieved by medical treatment, but in the severer types, the tumor should be removed. Interruption of the pregnancy should not result from the operation. On the contrary, myomectomy seems to prevent miscarriage. Corpus-luteum hormone and wheat-germ oil should be administered prophylactically, whether the fibroid is treated conservatively or removed.—R. J. Hefferman, M.D., *New Engl. J. Med.*, 1941. (Clinical Abstract.)



## RESEARCH DEPARTMENT

*The JOURNAL is making available to New Jersey physicians a special section in which short articles on original research will be published.*

### **PATHOLOGICAL CHANGES IN THE URINARY TRACT FOLLOWING EXCESSIVELY LARGE DOSES OF RIBOFLAVIN**

By WILLIAM ANTOPOL, M.D.

From the Division of Laboratories of the Newark Beth Israel Hospital, Newark, N. J. Presented at the Special Research Conference on Vitamins of the American Association for Advancement of Science held on Gibson Island, Md., July 25, 1941.

In the course of studies on the toxicity of vitamins it was observed that after the administration of exceedingly large doses of riboflavin, a precipitate of this vitamin occurred in the kidneys and urinary tract of rats. While these changes were found after the administration of free riboflavin, the results were even more striking after the administration of the sodium salt. The latter group is the subject of this report.

*Method:* A 2½ per cent solution of sodium riboflavin in saline was administered intraperitoneally in doses varying from 125 to 500 mg/kg body weight to male rats weighing between 225 and 275 gms. The animals were sacrificed by decapitation at intervals and the organs were examined grossly and microscopically. In many instances, at this time the blood was obtained for blood urea nitrogen determinations.

In another series, the kidneys, liver, and small intestine were taken for biological assay of riboflavin.

*Results:* Three to five minutes after sodium riboflavin administration the rats became very quiet and did not move. Later, though still motionless, they were quite irritable, and attempted to bite at the slightest provocation.

Five deaths occurred in 24 hours. One death occurred in four days; 13 rats were sacrificed in the first 24 hours, the rest at longer intervals.

In five to fifteen minutes the animals began to pass a few drops of bright yellow urine in which a fine yellow crystalline precipitate was found. Gross hematuria was not evident. The

urine became scantier and marked oliguria or anuria supervened.

Most of the rats which were sacrificed after 24 hours showed marked increase of urea nitrogen, in some rats it reached 160 mg. per cent.

The animals lost weight rapidly, many as much as 60 gr. in the first four days.

In the rats sacrificed five to fifteen minutes after the administration of the riboflavin, the entire kidney showed a yellowish hue and was slightly edematous. The ureters contained a considerable amount of yellow crystals of riboflavin. The papilla of the kidney contained a dense aggregate of riboflavin at the tip with a few very fine, bright yellow, linear, radiating streaks extending towards the cortex.

In 24 hours, the ureters were filled with compact aggregates of riboflavin crystals. The riboflavin in the papilla became so pronounced that it appeared as a triangular yellowish mass with numerous coarse radiating strands (instead of the finer ones seen earlier). Some of these strands extended to the very surface of the kidney. An occasional deep yellow dot was seen on the surface. The cortico-medullary markings were indistinct. In some rats in which the edema was extremely pronounced, the radiation of riboflavin was not as striking as in those in which the edema was less marked. In 48 hours the edema very often was so pronounced as to give a glassy appearance to the cut surface of the kidney, and except for some inner cortico-medullary congestion, the markings were indistinct. The kidney was very anemic.

In about four days, at times less, in addition to the above findings an occasional whitish, pin-point spot could be seen on the surface of the kidney with similar spots scattered throughout the cortex. The larger blood vessels were prominent and appeared rigid, and the aorta in one case assumed a pipe-stem appearance and showed calcification.

The kidneys of the animals sacrificed in about two weeks were still edematous; the cortico-medullary markings of the cut surface were indistinct. Some minute yellow flecks and occasional depressed area was seen on cut section. On the surface, however, minute grey dots were visible mingled with scattered pits. After two and one-half months in one rat the kidney surfaces had depressed areas and assumed a finely granular appearance with an occasional grey dot. Grey dots were also present on the cut surface.

The ureters and renal pelvis in the first few days contained crystals of riboflavin, and showed only slight dilatation. After three days, as a rule, there was slight dilatation even though no crystals were present.

Massive peritoneal riboflavin deposits were present in the first days after administration. These gradually diminished, but were still prominent two weeks after the administration of riboflavin. The riboflavin was usually found in the omentum, which was matted together, on the anterior surface of the liver firmly adherent to a thickened capsule, and in the scrotum about the epididymis. After many months, omental thickening and thickening of the liver and kidney capsules were prominent, and yellowish and grey nodules were present in these regions.

In the first few days the adrenals were often greatly enlarged and the cortex and cortico-medullary areas were markedly congested. In the later periods the size returned to normal, but the cut section had a browner hue.

The duodenum, 15 minutes after the injection, was filled with a deeply yellow-staining, limpid fluid which had the color of the riboflavin solution. This was present for a few days.

*Microscopic examination:* Fifteen minutes after the administration of riboflavin the kid-

neys showed marked congestion. There was moderate dilatation of the loops of Henle, and slight widening of Bowman's spaces. The papillary ducts were dilated and contained coagulum with linear clefts from which the riboflavin had been washed out. This was confirmed in the unfixed fresh frozen section. The veins were dilated in the kidneys as well as the subepithelial layers of pelvis and ureters. After one hour the venous dilatation of the kidney was more pronounced. The collecting tubules were dilated and some of these also contained a coagulum with clefts. A similar coagulum was also seen in the pelvis. At this time basophilic globoid bodies were seen in the distal convoluted tubules and the coagulum extended in places to tubules which reached the surface of the kidney. The glomerular spaces were not exceptionally dilated, but the basement membrane in the glomerular tufts was prominent. In 24 hours the scaffolding of coagulum with the riboflavin meshes was also striking in the cortex. There were occasional necrotic tubules which were difficult to identify, but in places resembled convoluted tubules. Some of the collecting tubules contained globules of calcium and, in places the convoluted tubules were vacuolated. In some of the collecting tubules, occasional groups of yellow crystals were seen in the paraffin sections which had not been washed out despite the paraffin embedding and passage of the tissue through an aqueous staining process. It remains to be determined whether these might be a conjugated form of riboflavin. The peripelvic and periureteral tissues were very edematous and contained monocytic cells. In about four days dilatation and calcification of some of the collecting tubules was found. The convoluted tubules were often eosinophilic and vacuolization was pronounced. The calcification of the tubules became more pronounced and the inflammatory reaction increased in some cases. Many of the papillary ducts contained polymorphonuclear leucocytes, nuclear debris and some ovoid calcium granules. In some of the animals there was extensive medial calcification of the larger blood vessels, and in one case even the aorta showed extensive medial calcification. In about two weeks, round

cells appeared in the interstitial tissue of the kidney and some of the kidney tubules became cystically dilated. The blood urea nitrogen at this time was still considerably elevated. In about two months there still remained considerable calcification of the tubules. Some of the papillary ducts were dilated and pyelonephritis was not uncommon. Depressed atrophic areas with lymphocytic infiltration were present, often at the surface of the kidney. Some of the arterioles were thickened. The pelvis showed areas of squamous cell metaplasia, and a ureteropyelitis and periureteropyelitis were present.

The heart often showed occasional collections of monocytes and histiocytes. The adrenals, in the first few days, were markedly congested and small cortical hemorrhages were seen at times. The cells in the fascicularis had a dense eosinophilic cytoplasm with few vacuoles. Eosinophilic cells seemed to be more numerous than normal in the pituitary gland. In the pancreas, vacuoles were seen in the exocrine elements, and the islands also appeared swollen. In one case there were scattered areas of calcification in the voluntary muscles.

Four rats were dosed with a suspension of 500 mg. sodium riboflavin per kg. Two of these, Nos. 1 and 2, were sacrificed in four hours, and two more, Nos. 3 and 5, in 24 hours. The findings are listed in Table 1, as determined by microbiological assay.<sup>1</sup>

TABLE 1

Rat No.	Animal Wt. G.	Dose in mg.	Mg. Riboflavin in		Liver
			Both Kidneys	Small Intestine	
1*	252	126	30.0	5.0	1.8
2*	219	109	16.0	7.0	1.4
3**	229	115	10.0	2.4	1.9
5**	249	125	16.0	8.0	1.5

\* Killed after 4 hrs.

\*\* Killed after 24 hrs.

1. Snell, E. E., and Strong, F. M.: *Industrial and Engineering Chemistry, Analytical Edition*. 1939, 11:346.

In control rats on a normal diet, the kidneys contain about 100 mg. riboflavin, the liver 350 mg., and the small intestinal content, about 45 mg. This contrasts markedly with the excessive riboflavin content in the treated animals. As may be seen from the table, the riboflavin in the kidney is not higher after 24 hours, than after four hours. This might be due to the increasing edema of the kidney.

The riboflavin increase in the small intestine over the normal could be accounted for by excretion from the liver and possibly the pancreas. The comparatively small increase in the liver might be due to spillover from this organ after a threshold has been reached.

Physical analysis of the crystals: Six hundred mg. of sodium riboflavin was administered intraperitoneally to each of 10 rats, and 36 hours after the administration of the vitamin the animals were decapitated. The kidneys were dissected out and on section frank concretions were macroscopically evident in the kidneys of each of the animals used. The calyces were dissected out and extracted three times with 10 cc portions of boiling 10 per cent trichloroacetic acid in the absence of light. The protein residue was colorless.

Examination of the solution in the ultra-violet and the visible showed the absorption bands characteristic of riboflavin with maxima at 2670 Å°, 3725 Å°, and 4450 Å° and minima at 2400 Å°, 3100 Å° and 4000 Å°.

*Summary:* The administration of excessively large doses of riboflavin results in precipitation of this vitamin in the kidneys and urinary tract of rats. A resultant obstructive and inflammatory lesion with uremia and a calcifying nephrosis may ensue.

Appreciation is expressed to Dr. R. H. Silber and to Dr. J. V. Scudi for the microbiological and chemical analyses. This work was undertaken by the writer in collaboration with Dr. Hans Molitor of the Merck Institute for Therapeutic Research.



## STATE ACTIVITIES

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### THE 176TH ANNUAL MEETING

An enthusiastic group of 1281 persons attended the 176th Annual Meeting in Atlantic City of The Medical Society of New Jersey in April. With perfect weather, an interesting program, and a galaxy of speakers on subjects of interest to the general practitioner as well as to the specialist, a good meeting was assured.

The scientific and technical exhibits were well selected and displayed, and the attention given these exhibits was gratifying and incidentally was encouraging to all exhibitors.

The awards made to scientific exhibitors were well merited. Scientific moving pictures, with sound to provide explanations by the competent medical creators of these films, were offered. This feature we hope to enlarge in the future, since medical research is likely to be curtailed by men called to service and the scarcity of funds necessary to carry on the work. These essentials are needed to win the war.

Delegates from the New York and Connecticut State Medical Societies and representatives from the War Department and Medical Schools who participated in the program, interpreted the war efforts and requirements as they relate to the responsibilities of the physicians, and proved both instructive and interesting to the members of our Society in New Jersey. Two general sessions, one devoted to Medicine and one to Surgery in War Time, were provided and were well attended and the contributions well received. In the Seven Special Sections the latest intensive studies in the restricted fields were discussed before good sized groups composed of members who devote themselves to one of these specialties. The social features were as usual among the most popular features of the meeting. Mennen's "Social Hour" was as popular as ever, and provided a welcome preliminary to the President's Banquet and Ball—held in the Rutland Room, which was filled to capacity on Wednesday evening.

Dr. Hilton S. Read served, in his own inimitable way, as a most successful toastmaster. The guest speaker was Colonel George F. Lull, M.D., Assistant in the Office of Surgeon General's Office of the War Department in Washington, D. C. Colonel Lull's subject was "Problems of the Personnel Officer", which he contrived to make interesting and profitable to the physicians who heard him. Colonel Frank

S. Gillespie of the British Military Service, who is now in the country as Liaison Officer to the Carlisle Medical School, was a guest at the speakers table with the officers, Chairman of the Annual Meeting Committee and their wives and the new President of the Woman's Auxiliary.

Entertainment was provided at the Banquet by the Adelphia Quartet and the Musical Trio. Dancing followed the banquet and this feature was enjoyed by a goodly number.

Dr. Watson B. Morris, Junior Fellow, fittingly presented to President Lewis the Fellowship key, and welcomed him to this very select fraternity.

President Thomas K. Lewis greeted the members and their guests and gave a fine, frank and clear picture of the strength and weaknesses of the average physician, and his advice was constructive as were his proposals for the safeguarding of our profession and the public.

President-Elect Dr. Elias J. Marsh lauded Dr. Lewis' accomplishments and modestly stated that he has taken as his own criterion of success in the next administrative year—"50 per cent of Tom Lewis' achievement". Mrs. Oswald R. Carlander, President of the Woman's Auxiliary, greeted the Auxiliary members and guests.

The business and organization meetings of the Delegates, Trustees, Committees and Councilors were carried out with commendable zeal. The discussions evidenced a solidarity in the aims of organized medicine and made manifest an increasing awareness on the part of the members of the evolutionary changes and trends in which the practice of medicine and the distribution of modern medical services are being increasingly involved. To "patient and physician relationships" are now added the State and community relationships to the medical profession, with more tangible evidence of increased effort being made to solve this newer and larger problem which now confronts the medical profession, not only in the present emergency but in the post-war peace era which will follow. There were physicians present and participating, not only private practitioners but also their colleagues who are engaged in practice in hospital and other types of administration, in institutional and industrial medical practice, in government service and with

the armed forces, in medical research, in medical education, in experimentation to better distribute to groups medical services and costs on a voluntary insurance basis, and to indigents at government expense. No one can *justly* charge the profession with failure to keep abreast with sound progress, but all changes advocated by enthusiasts in and outside the profession are not necessarily desirable or beneficial, and it was to provide these safeguards that the many topics listed were freely discussed by those in the profession best fitted to insure *evolutionary* instead of *revolutionary* changes and improvement. The *details* of the program can be found in the April *Journal* with the Annual Reports of Officers and Committees. The Transactions of the meeting will be issued as a supplement to an early issue of the *Journal*, and will provide a detailed account of all that took place during the three days of the Annual Meeting. President Lewis closed his administrative year in an atmosphere of general approbation and approval. Dr. Marsh takes over the duties of President under these auspicious circumstances which will give him a good start even in the trying times which lie ahead of us for the duration.

The Woman's Auxiliary meetings and exhibits were attractive, and provided entertainment and enjoyment for the ladies and visitors. Discussion of plans for the future and the relaxation necessary for their busy husbands kept the Woman's Auxiliary members busy. Those members and their wives who missed the opportunities and benefits provided by the Annual Meeting Committees of the Medical Society and the Woman's Auxiliary should

plan *now* to be with us at the meeting next year in Atlantic City.

#### OFFICIAL REGISTRATION OF THE 1942 ANNUAL MEETING

County	Delegates	Members	Total County	Woman's Auxiliary
Atlantic .....	11	70	81	43
Bergen .....	13	9	22	10
Burlington ....	7	16	23	19
Camden .....	9	42	51	25
Cape May ....	4	10	14	2
Cumberland ..	4	9	13	
Essex .....	60	86	146	42
Gloucester ....	5	10	15	13
Hudson .....	27	27	54	21
Hunterdon ....	3	1	4	
Mercer .....	12	37	49	15
Middlesex ....	7	19	26	15
Monmouth ....	9	19	28	7
Morris .....	9	14	23	
Ocean .....	3	5	8	3
Passaic .....	12	6	18	9
Salem .....	3	5	8	
Somerset ....	3	10	13	2
Sussex .....	1	..	1	
Union .....	20	33	53	13
Warren .....	3	4	7	5
	225	432	657	239

#### SUMMARY

Total New Jersey Physicians .....	657
Total Visiting Physicians .....	40
<hr/>	
Total Physicians .....	697
Woman's Auxiliary .....	239
Exhibitors .....	108
Visitors .....	237
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Total Registration .....	1,281

## SCIENTIFIC EXHIBITS AWARDS

### "For Meritorious Individual Investigation"

First Award: Oxygen in Blood—Clinical Significance and Measurement

W. G. Exton, M.D.; A. R. Rose, Ph.D.; F. Schattner, Ph.D., and S. Korman, Ph.D., Laboratory and Longevity Service, Prudential Insurance Company of America, Newark, N. J.

Second Award: Cystoscopic Photograph

Lowrain E. McCrea, M.D., Temple University Medical School, Philadelphia, Pa.

Third Award: Surgical Treatment of Cancer of the Rectum and Sigmoid with Perineal Anus

W. Wayne Babcock, M.D., and Harry E. Bacon, M.D., Temple University School of Medicine, Philadelphia, Pa.

### "For Meritorious Excellence"

First Award: Pathology of Arthritis

Samuel A. Goldberg, M.D.; S. N. Blackberg, M.D., and P. Stanley, Presbyterian Hospital, Newark, N. J.

Second Award: Traumatic Surgery and Plastic Repair—Repair of Traumatic Injuries

Morton I. Berson, M.D., Pan-American Clinic, N. Y. C.

Third Award: Bronchiogenic Carcinoma—An Analysis of Fifty-six Histologically Proven Cases

Thomas J. White, M.D.; Samuel Cohen, M.D., and A. M. Gnassi, M.D., Jersey City Medical Center, Jersey City, N. J.

## INFANT RESUSCITATION

A newborn infant who does not breathe spontaneously within thirty seconds after birth is in danger of asphyxia and attempts should be made to initiate respiration. The asphyxiated infant is often in a state of shock and it should be handled with extreme gentleness. These babies chill easily. Their temperature regulation is unstable. Maintain normal body temperature by carefully controlled external heat. The upper air passages must be cleared of any obstructing material by:

1. Suction with a large, soft rubber ear syringe aided by extending the head and stroking upward gently over the larynx.
2. Aspiration by mouth suction through a soft rubber catheter with saliva trap.
3. Direct laryngoscopy and aspiration in the severely asphyxiated cases.

An adequate supply of oxygen must be

maintained until the infant's respiratory center is functioning normally. Efficient cabinets, tents or masks should be used. In deeply asphyxiated babies, mechanical resuscitators may be needed, such as the E & J Resuscitator, the Drinker Respirator or other Council Accepted apparatus.

If the above therapy is unsuccessful due to a markedly depressed respiratory center with deficient circulation as caused by maternal sedation, narcosis or anesthesia, drug stimulation may be helpful. Inject 1/20th of a grain of alpha lobelin into the umbilical vein or 1/2 to 1 ampoule of coramin subcutaneously.

All brutal manual methods are contraindicated as futile and dangerous. These include vigorous swinging, slapping, and stretching the anus. Alternate hot and cold baths and cold applications can only be harmful.—Prepared by the Child Welfare Committee of the Essex County Medical Society.

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## SAYS THERE IS NO VALID REASON TO MOVE A. M. A.

### ATLANTIC CITY SESSION INLAND

There is no valid reason for moving the Annual Session of the American Medical Association, scheduled for June 8-12 at Atlantic City, to any inland city because of the war, *The Journal* of the Association has been advised by Robert P. Patterson, Under Secretary of War. An editorial in its April 4 issue says:

"Several Fellows of the American Medical Association have suggested that the Atlantic City session might be removed to the interior of the country because of the possibility of increased danger on the sea coast. To obtain an official expression of opinion on this point, the editor of *The Journal* consulted Robert P. Patterson, Under Secretary of War, in Washington. Mr. Patterson writes:

Dear Dr. Fishbein:

I have your letter of March 23 raising the question as to whether it would be advisable to move the convention of the American Medical Association away from Atlantic City.

I know of no valid reason why this convention should not be held in Atlantic City. The partial blackout of that city has been ordered to provide safer passage of ships which would be silhouetted against the bright lights of the city.

I want to take this occasion to express my appreciation and that of the War Department for the splendid work that the American Medical Association is doing and will continue to do to aid the Army in the recruitment of physicians who are so badly needed.

ROBERT P. PATTERSON,

Under Secretary of War.

"The Atlantic City hotels report many reservations; several leading hotels are already completely reserved. The program is complete, including several special sessions devoted to military medical problems. The Convention Number (of *The Journal*), giving full details, is scheduled for May 2."

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## VITAMIN FILMS IN COLOR

Ely Lilly and Company, Indianapolis, announces the release of three 16-mm. silent motion pictures in color descriptive of vitamin deficiency diseases. The films are available to physicians for showing before medical societies and hospital staffs. One deals with thia-

mine chloride deficiency, one with nicotinic acid deficiency, and the third with ariboflavinosis. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication. They do not contain advertising



of any description, nor is the name of Eli Lilly and Company mentioned.

The films were made at the Nutrition Clinic of the University of Cincinnati at the Hillman Hospital, Birmingham, Alabama, where studies were initiated in 1935, under the joint auspices of the Department of Internal Medicine of

the University of Cincinnati and the University Hospitals of Cleveland. Subsequently, these investigations became a cooperative project between the Departments of Medicine of the University of Cincinnati and the University of Alabama, and the Department of Preventive Medicine and Public Health of the University of Texas.

## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

The following list covers February, 1942:

### ANTOPOL, WILLIAM (Newark)

Pathologic aspect of nutritional deficiencies in rats: 1. Lesions produced by diets free of vitamin B6 (Pyridoxine) and the response to vitamin B6. *Arch. Path.* 33:241-258, Feb. 1942.

### BAKER, CHARLES F. (Newark)

Movements of the pancreas. *Am. J. Digest. Dis.* 76-77, Feb. 1942  
Pancreatic calcification. *Radiology* 38:188-190, Feb. 1942.

### BELING, C. ABBOTT (Newark)

Movements of the pancreas. *Am. J. Digest. Dis.* 76-77, Feb. 1942.  
Pancreatic calcification. *Radiology* 38:188-190, Feb. 1942.

### BICK, EDGAR M. (Fort Monmouth)

Observations on the topical use of sulfanilamide derivatives. *J. A. M. A.* 118:511-513, Feb. 14, 1942.

### BINGHAM, ARTHUR W. (East Orange)

Ectopic and other accidents of pregnancy as causes of maternal mortality. Maternal welfare article No. 67. *J. M. Soc. New Jersey* 39:87-90, Feb. 1942.

### COHEN, SAMUEL (Jersey City)

Primary carcinoma of the bronchus. *J. A. M. A.* 118:862-865, Mar. 14, 1942.

### EAGLETON, WELLS P. (Newark)

Responsibility of the medical profession towards the political institutions of the nation. *J. M. Soc. New Jersey* 39:68-73, Feb. 1942.

### GNASSI, ANGELO M. (Jersey City)

Primary carcinoma of the bronchus. *J. A. M. A.* 118:862-865, Mar. 14, 1942.

### GORDON, J. BERKELEY (Marlboro)

Relation of the general hospital to psychiatry. *J. M. Soc. New Jersey* 39:84-86, Feb. 1942.

### HALLINGER, EARL S. (Trenton)

Annual registration of physicians. *J. M. Soc. New Jersey* 39:111-112, Feb. 1942.

### KALB, WILLIAM (Newark)

Amphetamine (benzedrine) sulphate and thyroid extract in the treatment of obesity: observations on 500 cases. *J. M. Soc. New Jersey* 39:74-75, Feb. 1942.

### KNAUER, C. H. (Trenton)

Simple method of timing blood coagulation. *J. M. Soc. New Jersey* 39:75, Feb. 1942.

### MARQUIS, W. JAMES (Newark)

Movements of the pancreas. *Am. J. Digest. Dis.* 76-77, Feb. 1942.  
Pancreatic calcification. *Radiology* 38:188-190, Feb. 1942.

### PRICE, PRESTON (Jersey City)

Primary carcinoma of the bronchus. *J. A. M. A.* 118:862-865, Mar. 14, 1942.

### SCHAAF, ROYAL A. (Newark)

Rôle of the general practitioner in appendicitis. *J. M. Soc. New Jersey* 39:76-79, Feb. 1942.

### SOMMER, GEORGE N. J., JR. (Trenton) by invitation with John Alexander (Ann Arbor) and Adrian E. Ehler (Albany)

Effect of thoracoplasty upon pulmonary tuberculosis complicated by stenotic tuberculous bronchitis. *J. Thoracic Surg.* 11:308-325, Feb. 1942.

### UNNA, KLAUS (Rahway)

Pathologic aspect of nutritional deficiencies in rats: 1. Lesions produced by diets free of vitamin B6 (Pyridoxine) and the response to vitamin B6. *Arch. Path.* 33:241-258, Feb. 1942.

### WHITE, THOMAS J. (Jersey City)

Primary carcinoma of the bronchus. *J. A. M. A.* 118:862-865, Mar. 14, 1942.

The following list covers March, 1942:

### BERNHARD, WILLIAM A. (Newark)

Cystic fibrosis of the pancreas: Report of a case, with clinical and pathological observations. *Am. J. Dis. Child.* 63:530-540, Mar. 1942.

### CHERRY, HOMER H. (Paterson)

Prevention of tissue emphysema following closed pneumonolysis. *J. Thoracic Surg.* 11:451-2, April 1942.

### CHURG, JACOB (Newark)

Determination of sulfanilamide and its derivatives in blood. *Am. J. Clin. Path. Tech. Sect.* 12:22-31, Mar. 1942.

- ELWOOD, B. J. (Jersey City)  
Importance of control of a pulmonary lesion where tuberculosis tracheobronchitis coexists. Arch. Otolaryng. 35:408-417, Mar. 1942.
- FOSTER, R. H. K. (Nutley)  
Assay of heparin. J. Lab. & Clin. Med. 27:820-827, Mar. 1942.
- GOLDENBERG, RAPHAEL R. (Paterson)  
Roentgenographic study of acute osteomyelitis of the fibula treated conservatively. J. Bone & Joint Surg. 24:447-451, April 1942.
- KAPLAN, S. BERNARD (Newark)  
Peptic ulcer of the esophagus. Rev. Gastroenterol. 9:108-112, March-April 1942.
- LEHR, DAVID (Newark)  
Determination of sulfanilamide and its derivatives in blood. Am. J. Clin. Path. Tech. Sect. 12:22-31, March 1942.
- MAHONEY, MRS. MADELINE P. (Atlantic City)  
Autobiography of a medical branch library. Bull. M. Library A. 30:218, April 1942.
- MARTIN, STEVENS J. (First Lieut. Med. Corps U.S.A. —Chief of Sec. on Anesthesiology and Operating Pavilion. Tilton General Hospital, Fort Dix)  
Instruction in anesthesiology at the Tilton General Hospital. Army Med. Bull. No. 60:108-113, Jan. 1942.
- MENZEL, A. E. O., Ph.D. (Squibb Institute of Research, New Brunswick)  
Studies on meningococcal infection. XII Immunochemical studies on meningococcus type II. J. Exper. Med. 75:437-452, April 1942.
- ORRIS, HAROLD J. (Hillside). and Jacobs, Lewis (New York)  
Intracutaneous immunization against scarlet fever. J. Pediatrics 20:466-474, April 1942
- PAGLIUGHI, J. J. (Jersey City)  
Importance of control of a pulmonary lesion where tuberculosis tracheobronchitis coexists. Arch. Otolaryng. 35:408-417, March 1942
- PITKIN, GEORGE P. (Bergenfield)  
Prolonged local or block anesthesia with regulated cell reception. Anes. & Anal. 21:83-95, March-April 1942.
- POTTER, B. P. (Jersey City)  
Importance of control of a pulmonary lesion where tuberculosis tracheobronchitis coexists. Arch. Otolaryng. 35:408-417, March 1942.
- RADOS, ANDREW (Newark)  
Marfan's syndrome (arachnodactyly coupled with dislocations of the lens) Arch. Ophthal. 27:477-538, March 1942.
- RAKE, GEOFFREY (Squibb Institute of Research, New Brunswick)  
Studies on meningococcal infection. XII Immunochemical studies on meningococcus type II. J. Exper. Med. 75:437-452, April 1942.
- ROBBIN, LEWIS (Newark)  
Cystic fibrosis of the pancreas: Report of a case, with clinical and pathological observations. Am. J. Dis. Child. 63:530-540, March 1942.
- SACCO, A. G. (Jersey City)  
Importance of control of a pulmonary lesion where tuberculosis tracheobronchitis coexists. Arch. Otolaryng. 35:408-417, March 1942.
- WATERS, EDWARD G. (Jersey City)  
Primary breech birth. Am. J. Obst. & Gynec. 43:715-719, April 1942.
- ZWEIFLER, NATHAN (Newark)  
Peptic ulcer of the esophagus. Rev. Gastroenterol. 9:108-112, March-April 1942.

## SUPPLEMENTARY LIST OF MEMBERS NO. 1

APRIL 25TH, 1942

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### REGULAR MEMBERS

- Allen, Arthur A., 365 Park av., Paterson (16)  
Allen, Edwin J., 266 Van Houten st., Paterson (16)  
Antopol, William A., 201 Lyons av., Newark (7)  
Assante, M. Hugo, Evesham av., Clementon (4)  
Balson, Zachary D. B., 49 Osborne ter., Newark (7)  
Bernson, Sam'l T., 33 Bartholf av., Pompton Lks. (16)  
Blackburne, George, 490 Central ave., Newark (7)  
Blanchard, Kenneth, 144 Harrison st., E. Orange (7)  
Brandenburg, Leo W., 2802 Blvd., Union City (9)  
Cartisser, Joseph J., Stanhope (19)  
Casagrande, Stephen R., 600 7th av., Belmar (13)  
Coburn, J. Wesley, 144 S. Harrison st., E. Orange (7)  
Cohn, George M., 748 S. 10th st., Newark (7)  
Conlon, Philip J., 25 James st., Newark (7)  
Crapanzano, Domenico, Essex Co. Hosp., Cedar Gr. (7)  
D'Agostini, Alfred J., 41 Columbia av., Newark (7)  
Darby, I. Kermit, 310 13th av., Newark (7)  
Decker, Frederick H., Frenchtown (12)  
Deignan, William L., 257 Dodd st., East Orange (7)  
Del Baglivo, Mario, 10 Centre av., Jersey City (9)  
Denig, Ralph D., 370 State st., Hackensack (2)  
Devlin, Arthur D., 617 Broadway, Newark (7)  
Downs, Louis S., 143 Roosevelt av., Carteret (12)  
Dwork, Harold K., 55 Chancellor av., Newark (7)  
Dwoyer, Leon C., 420 N. Wood av., Linden (20)  
Feigenoff, Israel, 665 Broadway, Paterson (16)  
Francy, Donald G., 314 Stuyvesant av., Lyndhurst (7)  
Fridrich, Harry E., 4172 Federal st., Camden (4)  
Gambacorta, Leopoldo, 397 N. 13th st., Newark (7)  
Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)  
Gleason, Thomas P., 82 Broadway, Bayonne (9)  
Grunt, Louis, 35 Shanley av., Newark (7)  
Guarraia, Joseph, 285 Van Winkle av., Hawthorne (16)  
Hasney, Frederick A., 292 Main st., W. Orange (7)  
Higgins, Thomas F., 146 Reid st., Elizabeth (20)

Holster, Stephen G., 951 Madison av., Paterson (16)  
Howard, James W., 87 Midland av., Montclair (7)  
Katz, Herbert I., 278 Park av., Paterson (16)  
Kavanaugh, Daniel E., 566 Mt. Prospect av., Newk (7)  
Kimler, Wm. D., 725 Collings av., W. Collingsw'd (4)  
Lamy, Anthony W., 560 Newark av., Elizabeth (20)  
Leaver, Morris H., Quakertown (10)  
Lehman, Irving J., 558 Central av., Newark (7)  
Levitas, George M., 77 Fairview av., Westwood (2)  
Liegner, Ben, 90 Shanley av., Newark (7)  
Lippincott, Lansing Y., 939 Park av., Plainfield (20)  
Little, Alonzo W., 120 Arlington av., Jersey City (9)  
Mangone, George F., 811 Palisade av., Union City (9)  
McCarthy, John J., 1001 79th st., North Bergen (9)  
McCluskey, Harry B., Morristown rd., Whippany (14)  
McLeod, Harry J., 71 Forrest rd., Tenafly (2)  
McWilliams, Charles E., Blackwood (4)  
Merkelbach, Walter P., 288 Broad st., Bloomfield (7)  
Norris, Henry M., 21 Sterling drive, S. Orange (7)  
Palladino, Alessandro, 157 S. Center st., Orange (7)  
Palmer, Gideon H., 28 Winans st., E. Orange (7)  
Pindar, Arthur W., 627 Queen Ann rd., Teaneck (2)  
Pollack, Louis, 1008 E. Jersey st., Elizabeth (20)

Radest, Louis J., 347 Broadway, Paterson (16)  
Roberts, David C., 211 4th av., New York City (7)  
Roberts, Edgar W., 760 Palisade av., W. New York (9)  
Rogers, Harry, 144 Harrison st., East Orange (7)  
Rubin, Harold, 527 Bangs av., Asbury Park (13)  
Scalessa, Mario F. T., 396 Broad st., Summit (20)  
Sinnott, Gerald W., Medical Center, Jersey City (9)  
Smith, Marshall, 62 Bayard st., New Brunswick (12)  
Snyder, Howard P., St. Thomas, Virgin Is. (18)  
Spurgeon, Chilton E., 19 Church st., Newton (19)  
Vermes, Leslie, 172 Main st., Franklin (19)  
Weinstein, Robert A., 214 Spring st., Newton (19)  
Wheatland, Marcus F., Jr., 727 Walnut st., Camden (4)  
Williams, Wm. C., B. Horse Pk. & Wyne av., H'd'n Hts. (4)

#### ASSOCIATE MEMBERS

Auerbach, Friedrich, 1449 Clinton av., Irvington (7)  
Daly, John F., Holy Name Hospital, Teaneck (2)  
Drewniany, Bernardine, 541 Page av., Lyndhurst (7)  
Lang, Richard E., 463 Passaic av., Passaic (16)  
Snook, Lee O., Jr., 141 Ridge rd., N. Arlington (7)  
Spence, Harold G., 205 Watchung av., Up. Mtcl. (7)

## OBITUARIES

### DR. GEORGE W. CUMMINS

Dr. George W. Cummins of Belvidere, New Jersey, died at Easton Hospital on April 17, 1942. Dr.



Cummins was born in Vienna, New Jersey. He graduated from Centenary Collegiate Institute in Hackettstown in 1881, Sheffield Scientific School at Yale in 1884, where he remained to teach for four additional years. He graduated from the College of Physicians and Surgeons, Columbia University, in 1890, and began

his practice in Belvidere the following year. Dr. Cummins was not only a professional medical leader, but evidence of his civic and social leadership in Red Cross, Boards of Health and Education, Masons, Maccabees and religious work, is seen in his acceptance and faithful discharge of responsibilities in all these fields over a long period of years. His interest in the historical background of his country and community is shown in the carefully prepared history of which he was the author. His professional associations are attested in his serving for forty years as Treasurer of the Warren County Medical Society, and his membership in the State Society, the American Medical Association and the Lehigh Valley Medical Association (Pennsylvania). Dr. Cummins was re-

cently elected an honorary member of the Warren County Medical Society.

Dr. Cummins' loss will be felt by all who knew him, and especially by his longest and closest associate and collaborator, his good wife, whom he married as soon as he began his medical career, and who has shared his difficulties and triumphs so ably and admirably.

### DR. ROBERT R. ARMSTRONG

The death of Dr. Robert R. Armstrong of Passaic occurred on April 6th, after a prolonged illness of two years. He was 69 years of age. Dr. Armstrong had an interesting and influential career and served his country in the last World War as Commanding Officer of Base Hospital 147 in France, and also served his county, as Surrogate for two terms, as County Physician for 16 years, and as Freeholder for six years. Dr. Armstrong conducted a successful campaign which resulted in the establishment of Valley View Tuberculosis Sanatorium that now remains as a monument to his civic interest and effort.

Dr. Armstrong was born in Canada but came to Paterson as a child. He graduated from the Paterson High School and the New York University Medical College, after which he took post-graduate medical work in Vienna and Leipzig Germany. He began practice in Paterson and later moved to Passaic, where he lived until his death. He was a member of Passaic County Medical Society, The Medical Society of New Jersey and the American Medical Association.



## ● THE BULLETIN BOARD ●

*A. M. A. 93rd Session — Atlantic City*

*June 8-12, 1942*

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The American Medical Golfing Association will hold its twenty-eighth annual tournament at Seaview Country Club, Atlantic City, on Monday, *June 8*. Forty trophies and prizes will be awarded.

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On *May 21* the Gloucester County Medical Society will meet at the Woodbury Country Club, Woodbury, at 9:00 p. m. Dr. Herbert T. Kelly, Philadelphia, will speak on "The Present Status of Deficiency Disease with Reference to Vitamin Therapy".

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The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Atlantic City by the American Board of Obstetrics and Gynecology from *June 4 through June 9, 1942*, prior to the opening of the Annual Meeting of the American Medical Association. The Board requests that all candidates use the new application form which has this year been inaugurated by the Board. These forms, together with information regarding Board requirements, may be secured from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pa.

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Members of The Medical Society may soon receive a visit from Mr. Joseph Merante, who has taken photographs of all the Trustees, Officers and Fellows, and who is engaged at present in securing photographs of the members of the Society for the files of the Executive Office. The Executive Office is anxious to secure a file of photographs of all members so that these may be available for making cuts and slides when needed in the Society's activities. There will be no charge to the physician for the single photograph taken for the Society's files, nor will there be any obligation to purchase photographs for personal use from Mr. Merante.

The State Board of Pharmacy of New Jersey has issued under date of March 24, a special announcement on the qualifications of the registered pharmacist examination during the war emergency. Copies of this announcement are available to those interested who will write to the Board of Pharmacy, State of New Jersey, Robert P. Fischelis, B.Sc., Phar.D., Secretary, 28 West State Street, Trenton.

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For the first time in medical history, a five-day cure for gonorrhea—a disease affecting "several millions" in this country—has been perfected and proved in large-scale tests, it was announced recently by Surgeon General Thomas Parran of the U. S. Public Health Service.

Sulfathiazole, a member of the "sulfamiracle" drug family, is credited in Dr. Parran's statement as capable of curing at least 80 per cent of all gonorrheal infections. Of the remaining 20 per cent, he said, many may be cured by another course of treatment with the same drug, or by other special methods.

The Surgeon General's announcement coincides with the appearance of an article describing the five-day treatment in "Venereal Disease Information", a medical journal published monthly by the U. S. Public Health Service. Entitled "The Management of Gonorrhea in General Practice", the article was prepared by the Executive Committee of the American Neisserian Medical Society, and bears the names of the country's leading authorities on the disease.

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The *Annals of Surgery*, the oldest surgical journal in the English language, is now to be translated in Spanish and appear monthly. This results from the negotiations of the Coordinator of Inter-American Affairs and Director of the Hispanic Foundation, together with one of the oldest and most respected publishing firms in Buenos Aires, Guillermo Kraft Company. No better symbolic demonstration can be given of the sincere willingness to develop permanent intellectual fraternization between surgeons of the two countries.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

The March 13th meeting was a special event—the meeting of the Fifth Councilor District, held at the Northfield Country Club, in Northfield, N. J. The five counties represented in Southern New Jersey are Atlantic, Cape May, Cumberland, Salem and Gloucester. The meeting followed a dinner and was conducted by DR. HARRY SUBIN, President of the Atlantic County Medical Society. DR. HAROLD S. DAVIDSON was the program chairman. Among the more prominent guests at the meeting were DR. EMANUEL LIBMAN of New York; DR. CHARLES H. SCHLICHTER, Chief of the State Emergency Medical Service and Chairman of the State Medical Preparedness Committee; DR. NORMAN SCOTT, Assistant Chief of the State Service; DR. LEROY A. WILKES, Executive Officer of The New Jersey Medical Society; and DR. THOMAS K. LEWIS, President of the State Medical Society. Also present were DR. SAMUEL B. HUGHES, President of the Cape May Society, and DR. FRED WANDALL, President of the Gloucester Society.

The guest speaker of the evening was DR. WILLIAM HARVEY PERKINS, Dean and Professor of Preventive Medicine, Jefferson Medical College, Philadelphia. His subject was "Untapped Resources in Preventive Medicine". The speaker stressed the importance of prevention of disease in private practice and stated that the maintenance of health is ten times harder than the care of the sick. There should be more periodic health examinations made and the doctor should spend more effort in conserving health and practicing preventive medicine. He should not be too busy curing the sick to have time to consider preventive measures. The speaker stated that about two per cent of illness in private practice was organic and 98 per cent non-organic disease due to such things as malnutrition, faulty posture and other minor defects. Preventive medical practice must be encouraged by educating the public. The doctor can do this for he is the health adviser of the community. Dr. Perkins urged doctors to develop higher standards of preventive medicine in every community.

The meeting of the Fifth Councilor District was a great success and was attended by approximately 75 physicians.

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on March 12 at Moorestown, N. J. PRESIDENT LE FAVOR welcomed DRs. DIVERTY and WOOD from Gloucester County and DR. HENRY DECKER from Camden County.

The scientific part of the meeting consisted of a sound motion picture in technicolor on "The Vitamin B Complex" shown through the courtesy of E. R. Squibb & Son. This motion picture was interesting and informative, and the composition was

well balanced. It dealt with both symptomatology and treatment of the vitamin B deficiency diseases.

DR. JOSEPH KUDER announced that the Burlington County Hospital had opened its new x-ray department, which has the newest deep therapy equipment and an ample supply of radium. On March 26, 1942, the new department will be formally opened. Dr. T. J. Summey and Dr. F. F. Borzell of the hospital staff and Dr. Stanley Reimann of Philadelphia will give scientific papers. All of the County Medical Society's members are cordially invited to attend.

DR. HENRY DECKER, who is in charge of the Emergency Medical Service of the southern part of New Jersey, attended the meeting at the request of Dr. Harry Rogers of the Medical Preparedness Committee of the County Society. Dr. Decker discussed and clarified several issues which were not previously made clear to many of the members.

The County Society went on record as urging each community in the county to prepare itself for any eventuality which may come out of this war.

### CAMDEN COUNTY

T. H. McGlade, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building on February 3, 1942, with DR. D. F. BENTLEY presiding.

The guest speaker of the evening was DR. JONATHAN E. RHOADS, Associate in Surgery, University of Pennsylvania. His subject was entitled "Newer Concepts of Liver Disease". The value of vitamin K and of dietary regulation in biliary obstruction were emphasized. Dr. T. K. Lewis opened the discussion.

DR. NORMAN SCOTT, Medical Director, Medical Service Administration, delivered a brief address on Plan Number 2. It was regularly moved and seconded that the plan be adopted.

DR. T. K. LEWIS suggested a committee be appointed to study the advisability of establishing a fund to be used for members of the Society who are called to military service, following their discharge from the service.

The operation of the Procurement and Assignment Service was explained by DR. HENRY B. DECKER, chairman of the local committee, and by DR. NORMAN SCOTT.

DR. D. F. BENTLEY spoke on Civilian Defense and urged the coöperation of all members in its establishment and operation.

Dr. George B. German presented the following memoir of DR. HOWARD F. PALM:

"Dr. Howard F. Palm, at the age of 86, died at his home, 614 North Second Street, Camden, N. J., on January 2, 1942. He was born in Orwigsburg, Pa., and moved to Schuylkill Haven two years later, where he received his early education. He later attended Union Seminary at New Berlin, Pa., and Pennington Seminary, Pennington, N. J., before

entering Jefferson Medical College in Philadelphia. He was graduated from Jefferson on March 12, 1881, and began his practice of medicine in Camden on April 28, 1881.

"Dr. Palm was the sixth generation of doctors in the Palm family, his great-great-grandfather, Dr. John Palm, having founded the town of Palmyra, Pa., in 1750.

"He was a member of the Camden County and the New Jersey State Medical Societies. He held the office of President of the Camden City and County Medical Society. He was also a member of the U. S. Board of Pensioners and served in the City Dispensary during his whole career as a doctor. Also, he was a member of the Philadelphia Medical Club and of the Physicians' Motor Club of Camden. On June 1, 1938, Dr. Palm was tendered a complimentary dinner in celebration of his 57th anniversary as a practicing physician.

"His first wife, who was Miss Ida Keefer, of Cressona, Pa., died in 1922. In 1923 he married Miss Lucie Hand of Port Norris, N. J., who survives him. He gave unselfishly of his time and energy to his many patients, and his friends will remember him as being kind, sympathetic, and generous."

At the regular meeting held in the City Dispensary Building on March 3, 1942, the scientific program consisted of the following:

"Child Health in War Time", by DR. ERNEST L. NOONE. Malnutrition problems which have developed in England as a result of the war were explained.

"Philadelphia's Program for the Care of Prematures" was discussed by DR. PASCAL F. LUCCHESI, and consists of the establishment of stations in various hospitals where expert treatment of premature infants may be obtained. The prompt reporting of these cases is urged.

DR. WILLIAM KIMLER, West Collingswood, was elected to active membership.

## ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine on Thursday, February 12, 1942. PRESIDENT FRANCIS C. WEBER called the meeting to order at 9:15 p. m.

Our meeting was greatly honored in having as speakers three top-ranking members of the State Society. First to address us was DR. E. J. MARSH, President-Elect of the State Society, who spoke on "The State Administrative Program". In his opening remarks he said that he was bringing a message from the President, Dr. Lewis. He let it be known that although we are at war and our first interest is to help in this effort, the interest of our President is to see that we have a successful Medical Service Administration.

DR. LEROY A. WILKES, Executive Officer of the State Society, spoke on the "Current Trend Toward Organized Medical Service". He gave us the reasons for organizing medicine in New Jersey. He went into the early history of The Medical Society

and told us that the purpose was to provide discussion by the members of the need for organization as a brotherly association or society.

The discussions were centered upon uplift and help to its members, and fees. The members were to include those who were qualified to practice in New Jersey as physicians. In 1825 the right was granted by the Legislature to the Society to grant the degree of M.D. Each year an expansion of the Society's program took place. Activities and guidance in problems concerning health, milk control, mental institution control, etc., were added to the list. And now the public is anxious for a wider distribution of medical care and service. The public is not complaining of the *quality* of the medical service it has received. It is up to us to see that it is given wider distribution of medical service.

COL. C. H. SCHLICHTER, Chief of Emergency Medical Services, New Jersey Defense Council, spoke on the "Status of the Doctors in New Jersey as Observed by the State Medical Preparedness Committee".

He gave us a brief outline of the scheme of the Medical Preparedness Committee; first of the United States, then of the State, then of the county and lastly of the community. He also related his experiences with the Selective Service Act and spoke highly of the physicians who were working on Examining and Advisory Boards. He gave especial credit to Dr. Roy Van Ness for the excellent fulfillment of his office as Essex County Chairman. He said in passing that 40 per cent of men examined were rejected by the local boards, while 16 per cent were rejected by the induction boards.

As to Civilian Defense, he said this was no Medical Society project but a state government affair. Each Chief of Emergency Service must be a doctor. The medical work of the Civilian Defense is to be handled by medical men. Proper coordination with the Red Cross, State Police, etc., is essential.

DR. Schlichter made a plea for doctors to volunteer to the Local Defense Council for some kind of work, and spoke about the physicians entering the armed forces of the United States, the Army and Navy. We must get in service and win.

Much is to be said to the credit of those who worked hard to make Nutrition Week a success. The program was held February 9th to 16th at the Hotel Suburban in East Orange. Here were shown Daily Foods for Defense.

The nutrition of infancy and childhood was diagrammed. The Babies' Hospital (Colt Memorial) sponsored the portion about mother's milk. How it was prepared, frozen into mint-like wafers and stored. These tablets could be obtained at any time, and be again dissolved and fed to premature and weak infants.

Charts of interest on obesity were shown. Those cases of obesity which were due to nutritional and glandular causes were listed.

"Vitamins for Health" were displayed by the Hocmann La Roche Co. A list and charts of vitamin deficiencies were displayed. Diets and insulin for diabetes made up another part of the exhibit.

The Medical, Dental Societies and the Red Cross



of the Oranges and Maplewood are to be congratulated on this timely exhibit.

Our County Society should indeed be proud of the fact that the new 1941 Year Book of Pediatrics edited by Prof. Abt, lists on its first page "Care of Premature Infants", the 16 rules formulated last year by our Child Welfare Committee. The closing paragraph states that "The groups presenting these recommendations are the Child Welfare Committee of the Essex County Medical Society, Child Health Committee of The Medical Society of New Jersey, Maternal Welfare Committee of the Essex County Medical Society, Maternal Health Committee of The Medical Society of New Jersey and the Hospitals Committee of the Essex County Medical Society."

The following were elected to membership:

Active—DRS. AARON H. HASKIN, CHARLES E. KIESSLING and SAMUEL PECORA of Newark; DR. ELWOOD K. JONES of East Orange.

Associate—DR. EDWARD B. SELF of Orange, DR. LEE O. SNOOK of North Arlington and DR. IRVING L. SPERLING of Newark.

#### MARTLAND CLINIC AT CITY HOSPITAL

On the second and fourth Tuesday evenings of each month there is held at the City Hospital, Newark, in the Martland Auditorium a clinic which is always well attended. Promptly at nine o'clock the session begins and at least six cases of interest are presented for diagnosis and for suggestions as to treatment. These cases are well worked up and presented by the interne and resident staffs. The attending and visiting staffs add their experience to the knowledge presented. Often the clinic is honored by having some well-known guest physician discuss the cases.

DR. HARRISON MARTLAND, Chief Medical Examiner of Essex County and Pathologist at the hospital, is Director of the clinic. The new epidiascope is used in presenting fresh specimens and Kodachrome photos of other specimens are shown.

The meeting is second to none in value as is proven by the large attendance. A hundred or more physicians avail themselves of this wonderful opportunity which is given to them to increase their knowledge of up-to-the-minute histology, pathology and medicine. All physicians are welcome.

The following were elected to membership:

Active—DRS. LEOPOLD GAMBACORTA and BEN LIEGNER of Newark; DR. ALESSANDRO PALLADINO of Orange.

Associate—DRS. MICHAEL A. MARCHIGIANO and DANTE P. MONACO of Newark; DR. FRIEDRICH AUERBACH of Irvington, DR. BERNARDINE DREWNIANY of Lyndhurst, DR. HAROLD G. SPENCE of Upper Montclair.

#### GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of *Gloucester County Medical Society* was called to order by the President, DR. WANDALL. After general business was discussed, DR. EDWARD A. STRECKER, Professor of Psychiatry,

University of Pennsylvania School of Medicine, gave a most interesting and timely talk on "Neuro-Psychiatric Problems in the Military Service".

Dr. Strecker stressed the fact that the doctor's army experience would be entirely new. There being a shortage of psychiatrists in the army, the regular medical officer would be confronted with all such types of cases. There will be little time for an examination and a correct diagnosis to be made on each case. The doctor in camp must act as a friendly counselor to the boys, especially, when they become down-hearted and lonely.

In World War I, one-seventh of all the casualties were neuro-psychiatric cases. Each case cost the government after the war \$4,000.

The cases that occur during combat duty might be divided symptomatically as follows:

1. *Physical symptoms*: Convulsions, coma, deafness, blindness, headache, paralysis of all kinds.

2. *Emotional*: Depressions, elations, irritability, fear, anger.

3. *Military misbehavior*: These cases might at some time be Fifth Columnists or even spies. They may even strike officers habitually and disrupt the entire camp.

Malingering is the deliberate attempt to evade military duty. Throughout the war, Dr. Strecker stated that every man, including the officers, were at some time essentially malingerers. The treatment of malingering is not important and should not be overstressed. Their symptoms might be easily corrected by a few minutes of careful advice.

He also stated that the medical staff and doctors must do all they can to improve the health of our present army. Medicine can only exist, as it is today, in a democracy. After all is said and done, the war is essentially won by its medical staff and officers.

#### HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on February 3, 1942, at the Masonic Club, Jersey City, with PRESIDENT A. J. CONY presiding.

The following communication was received from Dr. Harry R. North, Chairman of the Finance and Budget Committee of The Medical Society of New Jersey, relative to 1942 dues of active members serving full time in the U. S. Armed Forces:

"The Board of Trustees of The Medical Society of New Jersey, at a regular meeting held in Trenton on January 25th, 1942, approved the following action:

"The names of all active members of County Societies, who are serving full time in the armed forces, upon certification by their County President and Secretary, will be listed in the 1942 Official List without payment of their 1942 dues. The question of the payment or credit for their dues will be decided by the House of Delegates in April.

"Certification of such members must include the name, date of induction, and, if possible, the present address of each member listed."

The following members are now serving in the Armed Forces: Drs. Joseph A. Angelo, Army; Francis A. Barone, Army; Albert Betcher, Army; Urban R. Bigliani, Army; G. C. Brignola, Army; Henry A. Christian, Army; Robert Cosgrove, Army; Richard A. Cupaiuoli, Navy; G. Thomas De Fusco, Army; David J. Flicker, Army; Joseph D. Goldstein, Army; Alfred S. Goldsmith, Navy; Solomon Greenberg, Army; Harry Hauptman, Navy; Moses H. Holland, Army; Kenneth Judy, Army; Arthur M. Kraut, Army; Robert B. Lobban, Army; Frank A. Marshall, Army; Albert B. Rosenberg, Army; Albert V. Saradarian, Army; David B. Simpson, Army; Arthur B. R. Smith, Navy; Eugene L. Spohn, Army; Abram Weiss, Navy; Reuben Yontef, Army.

#### NEW JERSEY STATE NURSES' ASSOCIATION

The New Jersey State Nurses' Association asked the members to help oppose a bill being prepared for presentation to the New Jersey Legislature, placing certain nurses on an equal basis with duly qualified registered nurses of today, and granting them all the rights and privileges now given to R.N.'s.

The nurses for whom this bill is prepared are nurses who hold a diploma from an approved school but who did not register in New Jersey at the time of their graduation and did not take advantage of the waiver. Today these nurses, because of their inability to meet the State's requirements, are not eligible for the examination for registration.

The New Jersey State Nurses' Association believes that the principle involved is very closely related to the interests of the medical profession, and asks the coöperation of the Hudson County Medical Society in defeating such legislation.

DR. MAURICE SHAPIRO has been approved for the State Department of Health Syphilis Clinic at the Bayonne Hospital.

DR. W. HOMER AXFORD was made an Honorary Member of the Hudson County Medical Society.

DRS. C. PETERSON, E. M. KIELY and T. J. SCHUCK were reappointed to the Advisory Committee to the Nursing Activities Committee of the Hoboken Chapter of the American Red Cross.

It was regularly moved that of the \$8,000 the Society has in cash, \$5,000 be invested in Defense Bonds.

DR. MORRIS BRESEV of Jersey City and DR. WILLIAM P. YUNCK of Bayonne were elected to membership.

DR. RUSSELL L. CECIL, Professor of Clinical Medicine, Cornell University Medical College, New York, discussed the important subject of "The Problem of Chronic Joint Disease".

The discussers were DRS. JAFFIN, STOCKFISCH, TAFT, DODSON, LEIR.

#### MIDDLESEX COUNTY

Cyril S. Hutner, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, N. J., on Wednesday, February 18,

1942. The President, DR. M. F. URBANSKI, presided.

The following Associate Members were elected to full membership: DR. EDWARD F. DUSCHOCK, Perth Amboy; DR. GEORGE MILLER, formerly of Carteret (U. S. Army); DR. RENE G. SCHIRBER, New Brunswick.

Middlesex County Dental Society thanked the County Medical Society for the invitation to attend the January meeting.

DR. J. J. MANN's committee has the Medical Service Administration plan under advisement.

New Jersey State Nurses' Association's request for legislative support was referred to the Committee on Legislation with power to act.

On motion the annual registration of physicians was approved.

DR. J. J. COLLINS of Woodbridge and DR. H. VORHEES of New Brunswick were made Honorary Members as recommended by the Ethics Committee.

The Society decided that the Maternal Welfare Committee as a whole should assume the work of the Field Physician, with Dr. Calvin and Dr. Walker, and that some physician from South Amboy be added to the committee.

DR. EDWARD F. KLEIN suggested a joint meeting in June with the County Dental Society similar to the affair held last year. The third Wednesday in June was decided upon and Dr. Klein was appointed to take care of arrangements for this affair.

The Woman's Auxiliary provided entry blanks for the Hobby and Art Exhibit at the Annual Convention of the State Medical Society in Atlantic City April 21, 22 and 23, 1942.

DR. M. F. URBANSKI introduced the speaker of the evening, DR. JOHN SCUDDER, Instructor of Surgery, Columbia University, New York City. His subject, "Advances in the Treatment of Shock with Blood and Plasma", was excellently presented and was well received. Motion pictures and lantern slides illustrated his talk.

The discussion was ably led by DR. A. R. CASILLI, Attending Pathologist, St. Elizabeth and Perth Amboy General Hospitals.

Notice was received that several narcotic addicts are making the rounds of the physicians in this county. If seen, call the Narcotic Bureau—Lombard 2885, collect.

A committee was appointed to consider the establishment of a blood bank in the county with DR. Casilli as Consultant.

#### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

A timely topic, "Everyday Fracture Problems", was presented by DR. ROBERT H. KENNEDY, Assistant Clinical Professor of Surgery, College of Physicians and Surgeons, Columbia University, New York, for the fifth lecture of our Post-Graduate Education Course, held March 19, 1942, at 8:45 p.m., at the New Jersey State Hospital, Greystone Park, President Teller presiding.

More than seventy-five physicians were present, and they were reminded of the necessity for concern about the handling of fractures, in view of the

events transpiring since December 7, 1941. Dr. Kennedy stressed the importance of First Aid for Civilians, and the training of interne staffs in our hospitals, in handling various traumatic problems, particularly the early initial treatment of injuries, as a necessity in preparation for their work in the Army. It is equally as important to see that the civilian population with fractures be properly handled so that they too may be restored to function, because of the need for conserving manpower in the war effort.

He outlined some general rules: (1) That fractures should be reduced as early as possible. (2) Traction should be applied in compound fractures, even with the bone protruding from wound, and obviously contaminated, as there is less danger in transportation to the hospital where operation can properly be conducted within the desired six-hour period. (3) X-ray if possible, but not if it entails a long delay. (4) Anesthesia is important to induce muscle relaxation, not for the relief of pain. (5) Fluoroscope only to check up what has been done and only briefly, because of the danger to the operator in frequent exposure. (6) Debridement of damaged and devitalized tissue. In skull fractures which are compounded, remove dead tissue in and around wound, watch out for epidural and subdural hemorrhage, and it is important to rule out laceration of the brain.

Fractured hips should be nailed as early as possible and compound fractures should be left open as a matter of safety.

In conclusion, Dr. Kennedy stressed that all physicians who treat fractures should use judgment, and in particular should pay a lot more attention to the ordinary problems of trauma.

A number of members took part in the discussion.

DR. THOMAS PROUT of Summit was introduced, who briefly discussed the feeble-minded problem and the hopes of the Sterilization League that the county society will endorse Assembly Bill No. 170. He pointed out that there are 4,500 cases in our institutions for the feeble-minded, and in the entire State there are 80,000 such cases and even in the reformatories at Rahway and Jamesburg one-half of those boys are in the feeble-minded group.

## PASSAIC COUNTY

I. Okin, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Paterson Board of Health Building at 9:00 on Thursday evening, March 12, 1942. DR. SIGURD W. JOHNSEN presided.

DR. NATHAN NUSSBAUM was elected to Associate Membership. Four applications for Active and two for Associate Membership were received.

The following Delegates and Alternates were elected:

Delegates: Drs. Henry D. Bongiorno, Thomas A. Clay, A. Hobson Davis, Anthony J. Delario, Armand De Rosa, Raphael R. Goldenberg, Theodore K. Graham, Wayne W. Hall, H. Hale Hollingsworth, Morris Joseph, James R. Lomauro, Allan W. MacGregor, Richard J. McDonald, Lester F. Meloney,

David H. Mendelsohn, Joseph E. Mott, Charles J. Murn, Irving Okin, William Spickers, Leopold E. Thron, Jack C. Warburton, Earl L. Warren, Hans Wassing, Harry Wolfson, J. Allen Yager.

Alternates: Drs. Frank A. Barlow, Joseph V. Bergin, Sidneys Brooks, Homer H. Cherry, William A. Dwyer, Edward C. Edlkraut, Joseph R. Jehl, Burton O. Kinney, John E. Leach, Herman Levy, Robert N. MacGuffie, John B. McCue, Alfred D. Meneve, David Polowe, H. Eugene Reading, Joseph N. Roy, Charles B. Russell, Augustin M. Schultz, Frederick I. Schwartzberg, Louis G. Shapiro, Benjamin L. Steinberg, John J. Szymanski, James J. Vanderbeck, Fred Vosburgh, William L. Weintraub.

Member of the State Nominating Committee: Dr. Sigurd W. Johnsen; Alternate, Dr. Wayne W. Hall.

DR. LEROY A. WILKES spoke on the "Itch to Write". He gave practical suggestions on writing of articles for the *State Medical Journal*. Dr. Wilkes is the Executive Officer and Acting Editor of The Medical Society of New Jersey. Dr. Henry A. Davidson, Editor of the *Journal*, is in service of the Army of the United States.

DR. GEORGE T. PACK, Attending Surgeon, Memorial Hospital, New York City, spoke on the "Surgical Treatment of Cancer". He showed four stereoscopic motion pictures. By looking through polarized lenses the audience was able to observe these pictures which exhibit a marvelous depth of field. The four films shown were:

1. Partial Gastrectomy for Cancer.
2. Radical Groin Dissection for Metastatic Melanoma.
3. Interscapulothoracic Amputation.
4. Radical Mastectomy.

Dr. Pack commented on various details after the pictures were shown and there was open discussion, and questions by DR. SPICKERS, DR. DE YOE and DR. JOSEPH.

## SALEM COUNTY

Lee C. Hummel, M.D., Reporter

On March 20th the *Salem County Medical Society* held its regular meeting at the Tea Room in Salem. DR. E. E. EVANS presided over a well-attended meeting. We were pleased to have as a guest, LIEUTENANT KERR of the Delaware Ordnance Depot.

DR. JONAS of Salem and DR. LEHR of Pennsgrove were elected to the Society.

The committee for contacting the board of the Old Age Assistance reported on the fee schedules submitted by that board. A letter from the board was read, which informed the physicians of Salem County that they could accept the schedule or the board would deal with individual private physicians willing to accept their fees. Apparently Salem County physicians are still individualistic enough to reject the plan for a County Society agreement with the Board of Assistance.

DR. JOSEPH B. WOLFE, Professor of Cardiology at Temple University, Philadelphia, Pa., was the guest speaker. He gave an excellent and instructive talk on "Pitfalls of Medicine"—an informal dissertation on the problems met and the common mistakes



made by physicians in the treatment and handling of cardiac and vaso-motor cases.

Dr. Wolfe discussed the early recognition of low grade rheumatic heart disease, acute congestive failure, vaso-motor failure, arteriosclerosis and atheromatous disease.

His talk was very much enjoyed. Dinner was served in the tea room following the meeting.

### SUSSEX COUNTY

John E. Longnecker, M.D., Secretary

The regular Annual Meeting of the *Sussex County Medical Society* was held in Sparta on March 3. Dr. J. LONDRIGAN, Second Vice-President of The Medical Society of New Jersey, was present and explained the working of the new Medical-Surgical Plan. The plan was discussed and agreed upon by the Society members. It was decided not to have a post-graduate course this year.

The Venereal Disease Clinic was discussed and it was voted to urge that a clinic be established in Vernon, and that better follow-up of patients be worked out.

The Welfare Committee reported that this plan is working fairly well. The plan will probably be put in effect in other counties throughout the state if it continues to function as well as it has here.

Dr. J. CARTISSIER of Stanhope was accepted as a transfer member from the Hunterdon County Society.

The Society favors the proposed amendments to the State Society Constitution and favors annual registration of licensed physicians in the state.

The following officers were elected for the year:

President, V. E. BURN

Vice-President and President-Elect, L. B. DRAKE

Secretary, J. E. LONGNECKER

Treasurer, F. J. SCOTT

Reporter, C. E. SPURGEON

Delegate, J. G. COLEMAN

Alternate, J. H. SPENCER

Nominating Committee, Delegate, J. S. COLE-

MAN; Alternate, J. H. SPENCER

Censor, M. I. KIRSHNER

Trustee, J. H. SPENCER

### UNION COUNTY

F. W. Lathrop, M.D., Secretary

The *Union County Medical Society* met at Elizabeth General Hospital January 14, 1942, at 9 p.m. Dr. ARMSTRONG presided.

Dr. W. WAYNE BABCOCK, Professor of Surgery, Temple University, gave a comprehensive and interesting study of "Gastric Malignancy", with colored illustrations.

### MEDICAL PREPAREDNESS

Dr. NITTOLE, Chairman, discussed the need for examining physicians at the Newark Induction Board (Essex and Union Counties) five days a week, remuneration to be \$15.00 per day. Union County physicians were urged to offer their services as soon as possible.

### CIVILIAN DEFENSE

Dr. SCHLICHTER outlined the national need for doctors. He asked for volunteers to help the Red Cross teach First Aid Courses. Elizabeth General Hospital is offering a refresher course for physicians in Red Cross First Aid. He stressed the importance of representation by Union County at the January 15th meeting of the New Jersey Hospital Association in New Brunswick, at which meeting the Procurement and Assignment Service is to be presented to New Jersey physicians.

### STERILIZATION BILL

Dr. PROUT outlined the need for further consideration of the new Sterilization Bill which is to come before the State Legislature at an early date. He gave a brief history of the situation, stressing the increasing number of feeble-minded persons and the ever-present problem that they present. There are not sufficient institutions to properly care for this increasing number. Realizing that every physician must recognize the necessity for scientific handling of this problem, Dr. Prout asked that the County Medical Society endorse the Sterilization Bill.

Following the recommendation of the Executive Committee it was voted that the County Society purchase four \$1,000, Series E Defense Bonds.

Drs. SEYMOUR R. DEEHL of Elizabeth, STANLEY J. FINK of Roselle and WILLIAM W. WEISSBERG of Hillside were elected to membership.

The President read the following announcements:

1. Parke Davis motion picture "Sex Hormones, Physiology, Diagnosis and Treatment" is available for showing from February 2nd to 21st. If sufficient interest is expressed, the County Society could have a special meeting for this. No action taken.

2. Dr. Frederic W. Bancroft, speaker—"Emergency Care of Abdominal, Head, Chest Injuries, and Burns". Date: January 20th, 1942. Place: Elks' Club. Time: 9 p. m. This lecture is under the auspices of the Elizabeth Clinical Society and will be counted as the first in the Elizabeth General Hospital series.

3. The March meeting will be held at the Ilderan Club in Rahway.

### SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held in the Nurses' Home of Overlook Hospital on February 24th, at 9:00 p.m.

Dr. STEUART, the President, presided. There were 28 members and 11 guests present.

Dr. Steuart mentioned that the Summit Medical Society was arranging to hold its future meetings away from the hospital and that the Program Committee had arranged to hold the next meeting at the invitation of Dr. Prout at the Fair Oaks Sanatorium in Summit.

Dr. EDWIN ECKERSON, of St. Luke's Hospital in New York City, gave a very interesting illustrated talk on "Recurrent Hyperthyroidism". This was followed by discussion by the various members.

# WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Chairman Press and Publicity

## COMING EVENTS

### ESSEX COUNTY

May 25, 1942, 1:00 p.m.

L. Bamberger and Company Restaurant  
Annual meeting, installation of officers  
Luncheon

### GLOUCESTER COUNTY

May 15, 1942, 1:00 p.m.

Residence: Mrs. Ralph Venturo, Glassboro, N. J.  
Annual meeting, installation of officers  
Luncheon

### MIDDLESEX COUNTY

May 20, 1942, 1:00 p.m.

White Gate Inn, Route No. 34, below Matawan  
Luncheon and bridge with mah jong

### PASSAIC COUNTY

May 18, 1942, 1:00 p.m.

North Jersey Country Club  
Speaker: Mrs. M. Dahson  
Subject: Red Cross Activity  
Annual Meeting  
Luncheon

### WARREN COUNTY

May 19, 1942, 1:00 p.m.

Residence: Mrs. M. Varney, Washington N. J.

## ANNUAL STATE MEETING

Life has its compensations. We journey to Atlantic City, lose a fine President (what a short year it has been!) and gain another grand lady as new President. We shall remember the quiet efficiency of Mrs. Oswald R. Carlander and the pleasure we have gotten from our association with her in the past year. Mrs. J. Howard Hornberger, our new "leading lady", hails from Burlington County. Indeed, she has held every office in the Burlington County Auxiliary and five positions on the State Board. This is certainly a fine background for a successful and understanding regime.

The meeting at Atlantic City provided a nice balance of business and pleasure. The accomplishments of the counties, as read in the reports of the County Presidents, proves that the members of the Auxiliary keep abreast of the times. Activities which extended from the buying of a \$1000 defense bond, to baking and serving thousands of cookies, prove that our members are doing their full share of work.

At the luncheon honoring Mrs. Carlander and Mrs. Hornberger, Dr. Thomas K. Lewis told the members that we are the best propaganda agents that the Medical Society has. He feels that now, more than ever before, it is our duty to learn about our husbands' work. Because the services of every physician will soon be required in war or in civilian defense, Dr. Lewis feels that we must maintain and strengthen our own organization. "It will be

easier and more effective for the men to turn to you women of the Auxiliary for aid and co-operation rather than to the regular social and municipal agencies. The result of the survey made this year proves that you are equipped to be of real value to the profession," said Dr. Lewis.

Because Trenton is a much more centrally located city than her own, Mrs. Hornberger very generously suggested that the October meeting be held there. At the meeting of the new board the following officers and state chairmen were introduced:

President: Mrs. J. Howard Hornberger, Burlington

President-Elect: Mrs. Asher Yaguda, Essex

First Vice-President: Mrs. James H. Mason, Atlantic

Second Vice-President: Mrs. James J. McGuire, Mercer

Corresponding Secretary: Mrs. William Wells, Burlington

Recording Secretary: Mrs. Banks S. Baker, Camden

Treasurer: Mrs. Thomas P. McConaghy, Camden

Directors: Mrs. Chris P. Segard, Bergen  
Mrs. William C. Meineke, Union

Public Relations: Mrs. Don A. Epler, Essex

Archives: Mrs. C. Chester Chianese, Mercer

Publicity: Mrs. F. J. McCauley, Bergen

Entertainment: Mrs. James H. Mason, Atlantic

Revisions: Mrs. G. E. McDonnell, Burlington

Parliamentarian: Mrs. J. J. Ruvane, Hudson

Program: Mrs. R. J. McDonald, Passaic  
 Widows and Orphans: Mrs. W. D. Miningham,  
 Essex  
 Printing: Mrs. J. J. McGuire, Mercer  
 Credentials: Mrs. A. W. Pigott, Somerset  
 Organization: Mrs. E. M. Sickel, Ocean  
 Medical Defense: Mrs. Dean H. LeFavor, Bur-  
 lington

Arts and Hobbies: Mrs. Ily R. Beir, Atlantic  
 Finance: Mrs. C. I. Ulmer, Gloucester  
 Resolutions: Mrs. R. J. Faulkingham, Middle-  
 sex  
 Nominating: Mrs. Oswald R. Carlander, Camden  
 Legislation: Mrs. H. V. Hubbard, Union  
 Bulletin: Mrs. Samuel H. Jessuran, Essex  
 Arrangements: Mrs. F. A. Shimer, Warren

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## SALUTE TO MRS. ALLMAN

To Mrs. David B. Allman, champion convention and entertainment arranger, a hearty salute! Mrs. Allman labors throughout the winter months and in the springtime reveals to us the intriguing plans she has made for the Convention. Now that the annual State Meeting is over, and thanks to Mrs. Allman's understanding arrangements, we are still recollecting and relishing the fun we had, she tells us that it is time to be thinking about putting our best "bib and tucker" in order for the *next* convention.

The members of the New Jersey Auxiliary are to be hostesses at Atlantic City June 8th to 12th, inclusive, at the Annual Meeting of the Woman's Auxiliary to the American Medical Association. We will be welcoming members of our National Auxiliary from all over the country. Whether they are members of the Auxiliary or not, *all* wives and guests of doctors will be most welcome.

The registration desk opens on Sunday, June the 7th, at 11:00 a. m. at the official headquarters in Haddon Hall. On this day, from 2:00 until 4:00 p. m., the members of the Hospitality Committee will greet the members of the Auxiliary. An exhibit of work being done by county, State and national Auxiliaries will be presented on the sun porch at Haddon Hall.

On Monday, following the meeting of the Board of Directors, there will be a luncheon at 12:30 honoring the President-Elect, Mrs. Frank Haggard. Guests will be the Past Presidents and the members of the Advisory Council. From four until six the Auxiliary to The Medical Society of New Jersey will be hostesses at a tea in honor of Mrs. Haggard and Mrs. R. E. Mosiman, retiring President. On Tuesday the business session convenes at 9:00 a. m. at which time Mrs. Allman will be presented. Mrs. J. Howard Hornberger will give the address of welcome. At 12:30 a luncheon honoring the Past Presidents of the National Auxiliary, at which Dr. Frank Lahey will speak, will be held in the Rutland Room. The business session continues on Wednesday with the installation of officers before luncheon. Dr. Morris Fishbein will address the Auxiliary. The "husband's dinner" is slated for Thursday evening at 6:30 p. m. with the reception and ball at 9:00 p. m. On Friday, June 12th, there will be shopping and sightseeing tours under the auspices of the Hospitality Committee.

You will see why, with the responsibility for this ambitious program, Mrs. Allman needs our support. Let us turn out in full strength and maintain the Auxiliary's reputation for genuine hospitality. Mrs. Allman! you may count on us.

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## WHY NOT AN AUXILIARY DEFENSE PROJECT?

Much is said of the unique position held by the physician in his community. Lawyer, minister, teacher or tradesman do not hold in the minds of the people whom they serve quite the place set apart for the doctor.

We, as members of physicians' families, share the same influence accorded the men. Each day in pursuit of the fulfillment of our domestic duties, we contact endless numbers of people, our neighbors, those people who are patients of the members of the Medical Society. Is it not feasible that these neighbors

look to us for concerted activity in the present wartime program?

Why not an Auxiliary defense project? We grant that most of us are doing an extraordinary amount of work to help the war effort. Numberless organizations have sprung up, all needing help, and worthy. There are classes and courses and many new things that must be learned. These things all members are doing. We are not, however, doing anything *as an organization* and surely this is expected of us.



The choice of projects is unending. It is not important what we do, so long as we do it as a body. Dr. Lewis and Mrs. Carlander have shown us the way with the questionnaire tabu-

lating the potential strength in our organization. Let us turn that strength in the direction of collective aid for defense participation by the Woman's Auxiliary.

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## "M" Is for Mercer and Middlesex Counties

These articles, written by the Presidents of the County Auxiliaries, are published each month and describe the procedures, aims and pet projects of the County Auxiliaries.

### MERCER COUNTY

The year opened with a luncheon meeting in honor of the eight Past-Presidents. Our Scholarship Fund has started a promising candidate upon her course in the William McKinley Hospital School for Nurses. At Christmas time we gave a cash donation to the F. W. Donnelly Memorial Hospital.

At one of our meetings, a fine talk given by Mrs. Frank Glenn Booz, outlining the work being done by the United Service Organization in our local Soldier's Club, so interested the members that several have served there as hostesses. Others have sent cakes and cookies

to the men and still others have opened their homes to men in uniform on Sundays and holidays.

Our April meeting was held in the historic Trent House, and followed by a tea in honor of the wives of physicians who are in service. Special guests were wives staying temporarily in the neighborhood, of the officers stationed at Fort Dix. Many pleasant friendships had their inception at this social hour.

MRS. GEORGE N. J. SOMMER, President,  
Mercer County Component Medical Society Auxiliary.

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### MIDDLESEX COUNTY

To contribute our fair share to the country's war effort is now the aim of the Middlesex County Woman's Auxiliary. This contribution was started in March by the holding of a raffle, the proceeds of which will be used in buying a Medical Kit. Middlesex has enrolled a great many members in Red Cross First Aid courses. The Auxiliary initiated a campaign to knit sweaters for the boys at Fort Hancock and Fort Monmouth. This effort has been supplemented by many other local groups.

In our programs this year we have attempted to bridge the gap between our Auxiliary, the public and the medical profession. Foremost in this direction was the Medical March of Time. Our members gathered original material from modern medical libraries dramatically and realistically presented the advances in the various fields of medicine stressing advan-

tages offered to the public. The favorable reception this effort received may establish it as an annual institution. Medical superstitions were torn asunder at one of the meetings while a highly informative medical quiz brought most of the members up to date on modern medical topics.

Not only was the cooperation with the men's organization more spirited than ever, but the membership list was also markedly increased. The trend of the times is to establish all-out efforts in all lines of endeavor. This aim we carried out during the year. All enterprises of the Middlesex Auxiliary have been loyally supported by the members and their many friends.

ESTHER F. BRESLOW, President,  
Auxiliary to the Middlesex County Medical Society.

## BOOKS RECEIVED FOR REVIEW

ROENTGEN TREATMENT OF INFECTIONS. By James F. Kelly, M.D., F.A.C.R., and D. Arnold Dowell, M.D. Pp. 432. Chicago, Year Book Publisher, Inc. 1942. \$6.00.

METHODS OF TREATMENT IN POSTENCEPHALITIC PARKINSONISM. By Henry D. von Witzleben. Preface by Theodore J. C. von Storch. Pp. 164. New York, Grune & Stratton. 1942. \$2.75.

PREECLAMPTIC AND ECLAMPTIC TOXEMIA OF PREGNANCY. By Lewis Dexter, A.B., M.D., and Soma Weiss, A.B., M.D., in collaboration with Florence W. Haynes, Herbert S. Sise and James V. Warren. Pp. 415. Boston, Little, Brown & Co. 1941. \$5.00.

CLINICAL HEMATOLOGY. By Maxwell M. Wintrobe, M.D., Ph.D. Ppp. 792. Philadelphia, Lea & Febiger. 1942. \$10.00.

MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY. By Torald Sollmann, M.D. 6th ed. Pp. 1298. Philadelphia, W. B. Saunders. 1942. \$8.75.

SURGERY OF THE AMBULATORY PATIENT. By L.

Kraeer Ferguson, A.B., M.D., F.A.C.S., with a section on fractures by Louis Kaplan, A.B., M.D., F.A.C.S. Pp. 923. Philadelphia, J. B. Lippincott Co. 1942. \$10.00.

PEDIATRIC GYNECOLOGY. By Goodrich C. Schauffler, A.B., M.D. Pp. 384. Chicago, Year Book Publishers, Inc. 1942. \$5.00.

TEXTBOOK OF SURGERY BY AMERICAN AUTHORS. Edited by Frederick Christopher, B.S., M.D., F.A.C.S. 3d ed. Pp. 1764 with 1538 illustrations on 771 figures. Philadelphia, W. B. Saunders Co. 1942. \$10.00.

NEPHRITIS. By Leopold Lichtwitz, M.D. Pp. 328. New York, Grune & Stratton. 1942. \$5.50.

MEDICAL STATE AND NATIONAL BOARD SUMMARY. By William H. Krupper, M.D., with a foreword to the candidate by Earl S. Hallinger, M.D., Secretary of New Jersey State Board of Medical Examiners. Pp. 369. Paterson, N. J., The Colt Press. 1942.

INTERNAL MEDICINE IN OLD AGE. By Albert Mueller-Deham, M.D., and S. Milton Rabson, M.D. Pp. 396. Baltimore, Williams & Wilkins Co. 1942. \$5.00.

## BOOK REVIEWS

**The Essentials of Applied Medical Laboratory Technic;** details of how to build and conduct an office or small hospital laboratory at small cost. By J. M. Feder, M.D. Blood and Plasma Transfusion, by John Elliott, Sc.D. Pp. 241. Charlotte, North Carolina, Charlotte Medical Press. 1940.

The value of this text lies in its simplicity and its refusal to take anything for granted in its attempt to condense laboratory technique for the small laboratory or the practitioner's office. The full-page illustrations serve to demonstrate various techniques and offer valuable suggestions not commonly described. Of special value are the constant hints as to methods of assembling apparatus and of obtaining the necessary materials. Because of the apparent attempt at conciseness, the authors have limited the described methods to only the most accepted and most recent. The small chapter on blood transfusions offers some valuable information on this vitally important procedure of the day; unfortunately, the author has limited the technique largely to that of a single commercial set-up.

As a whole the text should prove a valuable aid to the technician in charge of the small office laboratory.

LESTER M. GOLDMAN, M.D.

**Clinical Immunology, Biotherapy and Chemotherapy in the diagnosis and treatment of disease.** By John A. Kolmer, M.S., M.D., Dr. P.H., Sc.D., LL.D., L.H.D., F.A.C.P., and Louis Tuft, M.D. Pp. 941. Philadelphia, W. B. Saunders. 1941. \$10.00.

It cannot be disputed that the laboratory is playing an ever-increasing rôle in the practice of medicine, and the comprehensive scope of the Kolmer

and Tuft book bears witness to this fact. This volume should be of interest to a much wider circle of readers than clinical pathologists.

The volume is divided into two parts, the first half of which deals with the general aspects of infection, immunity, serotherapy, and chemotherapy. This section includes a discussion of natural and acquired immunity, antigens and antibodies, anaphylaxis and allergy (its diagnosis and treatment), diagnostic serologic reactions, blood transfusions, and chemotherapy. The second section deals with the practical application in the treatment of specific diseases and a chapter is devoted to each of the important groups of diseases, for instance, staphylococcal, streptococcal, pneumococcal, meningitis, etc. Suffice it to say that all important diseases are covered including those of viruses origin. A brief discussion of parasitic diseases is also included.

In general, the authors have been successful in their presentation of this vast material in a manner to attract those interested in clinical medicine. The summaries given at the end of each chapter and the tabular arrangement of these summaries of the various diseases discussed will be very helpful to the reader.

The chapters on allergy and chemotherapy in the first section are excellent, as is much of the material on the various diseases. The reviewer looked in vain, however, for reference to Landsteiner's outstanding work on the azoproteins which forms the structural basis for any discussion on antigens and antibodies. Recent experience has shown that preserved blood can be safely used after storage up to ten days in the refrigerator and that "bank" blood has a wider scope of usefulness than is indicated by Kolmer and Tuft.

The book can be recommended to all physicians, especially because of the chapters on allergy and chemotherapy. It is not superfluous to add that in war times the contagious and infectious diseases assume additional importance and the book offers the physician an excellent opportunity to review this subject and the progress made in the specific chemotherapy with sulfonamides and their numerous derivatives.

PHILIP LEVINE, M.D.

**Occupational Diseases; diagnosis, medicolegal aspects and treatment.** By Rutherford T. Johnstone, A.B., M.D. Pp. 558. Philadelphia, W. B. Saunders. 1941. \$7.50.

With the majority of industrial plants employing only part-time physicians, it is inevitable that many plant physicians should find it difficult to familiarize themselves with the highly technical articles dealing with industrial hygiene and the medicolegal problems resulting from exposure to hazardous substances. This book, because of its method of presentation, should therefore be of particular interest to these practitioners and to beginners in the field of industrial medicine. Its appearance is especially timely in view of the fact that occupational disease has been recently included in the workmen's compensation laws of many states.

The author devotes an introductory section to the purpose of workmen's compensation, its administration, and the function of the physician. The greater part of the book is taken up with a discussion of the diagnosis, medicolegal aspects, and treatment of diseases produced by gases, solvents, fumes, metals, and dusts, and the dermatoses. Occupational cancer, heat and climate affections, electrical injuries, and caisson disease are treated in brief. There has also been included a chapter on each of the following: the "industrial back", hernia, the relation of trauma to disease, neurosis, and preemployment examination.

Dr. Johnstone emphasizes the fact that the physician "is not making an examination to disprove the patient's claim or the employer's contention. \* \* \* The duty of the doctor is to determine the cause".

HENRY H. KESSLER, M.D.

**Arthritis in Modern Practice; the diagnosis and management of rheumatic and allied conditions.** By Otto Steinbrocker, B.S., M.D., with chapters on painful feet, posture and exercises, splints and supports, manipulative treatment and operations and surgical procedures. By John G. Kuhns, A.B., M.D., F.A.C.S. Pp. 606. Philadelphia, W. B. Saunders Co. 1941. \$8.00.

Too long has the treatment of the arthritides been neglected by the general practitioner! Too long has there been a sense of defeatism when the general practitioner is confronted by an arthritic patient! Too long has the treatment of his disease group been limited to "R aspirin gr x t.i.d."! In reality there is more reason for optimism in the treatment of arthritis than there is in the treatment of arteriosclerosis or neoplastic disease.

Starting with an outline of the tremendous medico-social and economic problem presented by rheumatic disorders, the authors of "Arthritis in Modern Practice" pass on to the classification arthritis and related conditions. Each of the headings are then discussed separately as to definition, etiology, incidence, predisposing factors, symptomatology, pathology and treatment. It is gratifying to see that rheumatoid arthritis is stressed as a systemic disease. The sooner the medical profession as a whole recognizes this fact the fewer will be the cases of extreme crippling.

The subjects of the "painful shoulder" and the troublesome question of backache are ably discussed with many practical suggestions as to treatment. The subjects of posture, exercise, manipulative treatment and splinting receive the emphasis they deserve.

Though there are some points this reviewer would tend to question or wish to emphasize, this book is intended to awaken the general practitioner and to give him positive and practical information while avoiding the more controversial aspects of etiology and therapy.

"Arthritis in Modern Practice" is a definite contribution in the field of rheumatology and shows how with the intelligent application of basic principles the unfortunate arthritic patient can be helped and that defeatism on the part of the physician is entirely unwarranted.

GEORGE L. ERDMAN, M.D.

**Proceedings of the Charaka Club, v. 10.** Pp. 260. Baltimore, Williams and Wilkins Company. 1941. \$5.00.

Never was a reviewer's task more enjoyable. To open a book which contains the names of a few outstanding physicians and find thereafter discourses on fields far from medicine ranging from love and philosophy to rugs and history is a treat indeed. Of special interest is the paper on the "Early Years of the Charaka Club" by Bernard Sachs, one of the two living original members of the club. The volume opens with "The Story of Barbara Fritchie" by Walter E. Steiner, an essay which should be of more than a little interest to those south of the Mason-Dixon line who have often silently objected to the popular characterization of this woman. Among the twenty-one other essays are included "The Mystery of Robert Seymour" by Samuel W. Lamber which keenly analyzes the Dickens-Seymour affair leading up to the suicide of the latter; "Personal Recollections of Henry George" by Walter Mendelson, the title of which is self-explanatory; and a short tribute to one of the four founders of the Charaka Club. "Frederick Peterson—Sound Psychiatrist, Great Scholar, True Poet. A Friend's Tribute" by Bernard Sachs, also a founder.

This latest volume of the Proceedings of the Charaka Club continues a series of essays which are fine examples of the fruits of avocational endeavor and scholarly research. Would that there were more of it.

C. ABBOTT BELING, M.D.



**Behind the Mask of Medicine.** By Miles Atkinson, M.D. Pp. 348. New York, Charles Scribner's Sons. 1941. \$3.00.

To the doctor honestly interested in his profession and all its varied aspects, "Behind the Mask of Medicine" cannot be recommended too highly.

In the chronological treatment of the development of medicine, the lucid, analytical style of the author leaves little to the imagination of the reader. Relieving the ordinarily monotonous review of facts and statistics is a deft humorous touch, philosophical and satirical in turn, that not only entertains, but succeeds in holding the reader's attention and assists in ease of assimilation of the wealth of historical detail.

In treating with the problems of the medical man it can truly be said that the learned doctor "has pulled no punches", and his reasoning should find a full measure of agreement in his readers. There can be little criticism with his clear-cut treatment of the exploitation of the patient by the doctor or hospital and in turn, the converse: the exploitation of the doctor by the patient or the hospital. These conditions are only too familiar to anyone conversant of the subject of medical practice today. The fact that these highly controversial subjects are in effect, "the skeleton in the closet", makes this open treatment of them the more noteworthy.

The logic advanced by the author in his constructive criticism of these chronic ills, should give food for thought to any member of the profession. I say to any member of the profession advisedly, because if there is a criticism that might be levelled against this book, it is that outside of the profession, its utter frankness might be considered dangerous.

In refusing permission to some of my friends for a loan of this book, I can imagine the effect of such sentences as:

"Granted that most of the drugs we use today have been handed down to us from the Arabian physicians and are therapeutically useless", or

"Granted that a vast amount of money is wasted annually on medicines which from inactivity, inappropriateness or incorrect dosages fail to produce any remedial effect", or

"Many of them (speaking of minor complaints) cure themselves, at least temporarily. Nature does it, though doctors often take the credit."

To one familiar with the glib way the lay mind seizes on such sentences from a medical article in a journal, let alone an authoritative book by an eminent doctor, these and other outspoken criticisms of the shortcomings of the profession would seem to constitute a danger of misunderstanding by the lay mind. This reader feels that anything that tends to in any way affect the keystone of the medical arch, namely that nebulous, intangible, undefinable something we know as the confidence of the layman in his doctor, is dangerous regardless of its intent. The public is only too apt to concentrate on component parts and forget the pattern of the whole scheme, or, be unable to appreciate the whole picture.

In dealing with the exploitation of the doctor

by the hospital I was disappointed to note the absence of reference to the exploitation of the up-and-coming surgeon or junior staff appointee by his older and more secure brothers. That is, the situation where a man established in a community can with great magnanimity perform cut-rate operations or treatments for people able to pay a reasonable fee, thereby gaining that beneficent mantle of sweet charity through the plaudits of a grateful public, on the one hand insuring a constancy of clientele; on the other, removing from the orbit of the younger man a means of remuneration, experience and encouragement.

I felt, too, in that part dealing with the administrative and medical portions of a hospital, a word might have been apropos regarding the fairness of staff appointments in the hospitals, particularly where relating to the younger man coming up.

Regarding the treatment of the workmen's compensation feature of this book, I can only note that there is a vast difference in the administration of the workmen's compensation act referred to, and the one obtaining in this state.

Regardless of whether one agrees or disagrees with the eminent doctor in his treatment of socialized medicine, it must be readily admitted that his treatment of the situation is masterly, both as to the causes and the logical consequences. However, here again one's viewpoint is colored by his own experience and this portion of the book should provoke much debate.

In summing up, this reader feels: This book should be read and considered by every doctor and kept nearby for reference; it should be a must book for all ethics committees of the medical profession, but as previously indicated, it should not be strongly recommended for general public use.

FRANK W. O'BRIEN, Ph.D., Manager,  
Court Reporters' Office, New Jersey  
Workmen's Compensation Bureau.

**Primer on the Prevention of Deformity in Childhood.** By Richard Beverly Raney, B.A., M.D., and Alfred Rives Shands, Jr., B.A., M.D. Pp. 188. Elyria, Ohio, National Society for Crippled Children, Inc. 1941. \$1.00.

This primer on the prevention of deformity in childhood was authorized in 1937 by the professional advisory committee of the National Society for Crippled Children. The work is, of necessity, limited in its scope but would be useful for pediatricians, general practitioners, nurses and medical social workers. It will teach them how to prevent many deformities and also how to treat those that are present.

The book consists of 188 pages divided into four chapters. The first chapter deals with common affections of childhood which may cause deformity; the second deals with deformities of the upper extremity; the third with deformities of the lower extremity; the fourth deals with deformities of the neck, back and chest.

The numerous line drawings, by Jack Wilson, are very good and more effective than photographs.

TOUFICK NICOLA, M.D.

**Chinese Lessons to Western Medicine.** A contribution to geographical medicine from the clinics of Peiping Union Medical College. By I. Snapper, with a foreword by George R. Minot. Pp. 380. New York, Interscience Publishers, Inc. 1941. \$5.50.

Professor I. Snapper, Head of the Department of Medicine, Peiping Union Medical College, Peiping, China, has made a valuable contribution to Geographical Medicine in his book "Chinese Lessons to Western Medicine".

In his introduction, he speaks of the pitfalls which await a western clinician who has to deal with the problems of medicine in North China.

The incidence of various types of diseases differs greatly in the Occident and the Orient. For example, certain diseases are endemic or frequent in North China, such as cirrhosis of the liver, schistosomiasis, hydatid cyst, amebiasis, bacillary dysentery, Kala-azar, and certain avitaminoses. Most of these diseases are rarely encountered in the United States, if at all. Their frequency of occurrence in China makes them real problems. Occasionally we do see here a few cases of these oriental afflictions and it is wise for us to keep them in mind.

Dr. Snapper's book is not only very informative, but also beautifully prepared. The quality of the photomicrographs and the roentgenographic reproductions is as fine, on the whole, as this reviewer has seen in any publication. The entire work is a credit to the Peiping Union Medical College and to its author.

C. ABBOTT BELING, M.D.

**Psychiatric Social Work.** By Lois Meredith French. Pp. 344. New York, The Commonwealth Fund. 1940. \$2.25.

This book gives the results of a study covering the development and present status of psychiatric social work, its relation to the psychiatrist and the pediatrician, the hospital and clinic, and the part played by psychiatric social work in mental hygiene education. It should prove of real help in acquainting the physician with the functions of the social worker; for while there has been an increasing understanding of her value to the psychiatrist and the many agencies dealing with social problems that affect the health of the individual, it is the general practitioner who most often sees the patient at a time when proper recognition of the difficulty would have the greatest effect.

Of particular interest is the section on trends in social treatment. Three major changes that have become evident are: (1) A lessening dependence upon an approach based on the worker's analysis of the problem; (2) an emphasis upon the client's feelings and attitudes; (3) a realization of the greater efficiency of a treatment plan initiated by the client rather than by the worker. The recently advanced definition of case work as "individual therapy through a treatment of relationship" brought into focus the terms "attitude therapy" and "relationship therapy", and resulted in the acceptance of a "passive" rôle by the worker. The author analyzes the general nature of the work represented by these concepts and points to the

fact that techniques are still in process of evaluation. There is need for clarification of terminology and for a type of recording that would help formulate a definitive basis for a continuing study of the field.

The available data on the number of workers, educational requirements, job opportunities, and salaries have also been included, together with a history of the American Association of Psychiatric Social Workers. For those who wish to pursue special phases of the subjects, there are abundant footnotes and an extensive bibliography.

DORIS SOIBELMAN, B.S.

**Diabetes Mellitus.** By Zolton T. Wirtschafter, M.D., and Morton Korenberg, M.D. Pp. 186. Baltimore, William Wood of Williams & Wilkins Company. 1942.

This short monograph is unique in that only three of its thirteen chapters are about diabetes mellitus, diabetic coma, and complications of diabetes directly. The rest of the book is taken up with the metabolism and physiology of carbohydrates and insulin, the vitamins and endocrines. There is an excellent resumé of the acid-base equilibrium mechanism in concise and clear form, and special emphasis is based on the recent work on phosphorus metabolism and its relationship to glycogenolysis and glycogenesis.

The review of concomitant conditions in the various organic systems is brief and to the point but remarkably complete.

Even in the chapter on coma, physiology and metabolism are stressed, and the practical points of treatment, while enumerated fully, are not given in much detail. This is a book, then, not especially for the general practitioner, but one which, with its very complete bibliography, will be a real delight to the metabolist and the student of diabetes mellitus.

EVERETT O. BAUMAN, M.D.

**Nasal Sinuses; an Anatomic and Clinical Consideration.** By O. E. Van Alyea, M.D. Pp. 262. Baltimore, Williams & Wilkins Company. 1942. \$6.50.

The author has based his study on the examination of a large number of anatomic specimens, correlating this work with previously published material in the case of each set of sinuses and offering many clinical suggestions evidently based on considerable clinical experience. The pathology of sinusitis is discussed as a dynamic entity and not as a series of separate conditions, each distinct from the other. Treatment is based on the most recent concepts of nasal physiology, the author deploring the widespread use of harmful antiseptics within the nose, so prevalent in the past two decades. The work includes a thorough going review of the important literature relative to sinus disease and there are several brief chapters dealing with closely associated states such as allergy and the conditions elsewhere in the body affected by pathology in the sinuses.

EDGAR P. CARDWELL, M.D.



**The Blood Bank and the Technique and Therapeutics of Transfusions.** By Robert A. Kilduffe, A.B., A.M., M.D., F.A.S.C.P., and Michael De Bakey, B.S., M.D., M.S., F.A.C.S. Pp. 558. St. Louis, C. V. Mosby Company. 1942. \$7.50.

This book is an up-to-date and comprehensive survey of all the important literature pertaining to the many aspects of blood transfusion. The thoroughness of the authors is reflected in the enormous number of bibliographic references which appear at the end of each chapter.

Starting with a brief but interesting resume of the historical aspects of blood transfusion the subject matter goes on to include the rationale, indications, contra-indications, typing technique, compatibility tests, anomalous reactions and the question of the "universal donor" and "universal recipient". Then there is a section on the operation of a blood and plasma bank. Methods and technique of transfusion are discussed and finally a chapter is devoted to complications of blood transfusions.

The historical survey makes one realize that blood infusions from human to human are a relatively new addition to our therapeutic armamentarium. The section on the blood bank and preparation of plasma is comprehensive in its scope and contains many practical suggestions for the establishment and operation of such centers for blood and plasma storage. The sections on rationale, indications, contra-indications and complications are timely in view of the tendency on the part of some to order transfusions rather indiscriminately.

Dr. Kilduffe and Dr. DeBakey are to be congratulated for a valuable piece of work which not only represents the viewpoint of authoritative medical literature but also presents many practical points of procedure drawn from their own experience. The book is profusely illustrated and its style makes reading easy as well as profitable.

GEORGE L. ERDMAN, M.D.

**Clinical Application of the Rorschach Test.** By Ruth Bochner and Florence Halpern. Introduction by Karl Bowman, M.D. Grune and Stratton, New York. 1942. 220 pages. Price \$3.00.

To the uninitiated the Rorschach Test seems like so much black magic. The information which a Rorschach diagnostician can secure simply by subjecting the patient to a set of amorphous inkblots is amazing. Certainly no other objective test mirrors so quickly the deeper personality structure of the subject. Unhappily, too many Rorschach experts have kept the procedure mysterious not to say esoteric by refusing to provide any practical manual for administering, scoring and interpreting the experiment. Asked to make clear how he discovered so much about a patient's emotional state by quietly recording reactions to inkblots, the average psychodiagnostician smiles and says that it would take years to explain. Until now, only one book in English has ever been published which discusses the Rorschach method in any detail. And even this (Beck's monograph) is for the expert not for the beginner in the method.

Bochner and Halpern therefore do a real service

by making available a compact handbook on the administration and interpretation of the Rorschach procedure. The material is arranged logically; it begins with the test procedure, then demonstrates how to inscribe the scoring symbols, how to calculate the several formulas, how to interpret the findings. Some twenty protocols support the explanations. Of course no one will become a Rorschach expert overnight by reading this manual. But the psychiatrist to whom personal instruction is not available, will find this volume a perfect springboard for practice with this unique diagnostic instrument. If he buys a set of the Rorschach plates, studies the Bochner-Halpern volume, reads the *Rorschach Research Exchange*, and assiduously submits all appropriate subjects to the procedure, he should in a few months develop real skill in the visualization of personality structure through the inkblots.

If any fault may be found with this highly practical volume, it is with the form, not with the content. The absence of an index is a serious omission. A reader who wants to find, for example, the Rorschach method of estimating intelligence, has to leaf chaotically through the whole book. He can not look for "intelligence, estimate of" in the index because there is no index. And he cannot look for the corresponding chapter in the table of contents, because for some baffling reason the authors have given the title "Variants" to Chapter VIII—a chapter devoted entirely to the estimate of intelligence. A few critics may also take exception to the dogmatism of the authors, in stating that such and such a finding means such and such a trait. This objection, however, is not valid, as the authors make it clear that they are setting it up in this manner for the sake of simplicity; and for the further reason that constant emphasis is laid on the necessity of integrating each single finding with the whole pattern. The book is stripped of any theoretical discussions, and is trimmed to the bare essentials of the mechanics of administering and interpreting the procedure. Which, for a practical handbook, is as it should be.

HENRY A. DAVIDSON, M.D., Newark, N. J.

**Diet in Sinus Infections and Colds.** By Egon V. Ullmann, M.D. 2d ed. Pp. 185. New York, The Macmillan Company. 1941. \$2.00.

The old fetish of acidosis as a complicating factor in sinus disease is raised in this book, which proposes a diet to be used by those susceptible to colds and attacks of sinusitis. The diet consists in restricting salt intake to a marked degree on the basis that the chlorine is used to produce acid, and in placing the emphasis on the base-forming foods, so that the individual does not suffer from "acidosis". The author admits that the rationale of the treatment is more easily accepted on an empirical basis than on one of scientific investigation and reasoning. He also concedes that dietary treatment is but an adjunct in the therapy of sinusitis if there is obstruction or purulent infection present.

EDGAR P. CARDWELL, M.D.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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AS long ago as 1865 Villemin successfully passed the "virus" of tuberculosis from one animal to another. Twelve years later (and five years before Koch's discovery of the tubercle bacillus) von Tappeiner caused dogs to develop tuberculosis by allowing them to inhale sputum from a consumptive patient. While direct lip contact is today considered the most potent means of transferring tubercle bacilli from person to person, knowledge as to the relative dangers of indirect contact with tuberculous lungs and their secretions is still incomplete. Three recently published papers give evidence of this while, at the same time, they sharpen our perception of the manner in which bacilli get from host to victim.

### TUBERCLE BACILLI ON BOOKS AND GARMENTS

Books read by consumptives probably are occasionally contaminated by sputum in the form of droplets expelled during coughing or speaking as the book is closely held to the face and at a level that any droplets expelled may readily be deposited upon the paper. Also, they may be contaminated by licking the thumb or finger when turning the pages. Transmission of infection to a second reader appears most likely to occur when the recipient with moist thumb or finger handles the contaminated page, supposedly harboring the bacilli.

There is a general agreement that large portions of the bacilli deposited upon the book pages become dry and non-viable after a short period of time. Kenwood and Dowe exposed papers to coughing patients and dried them for one month, after which the washings from the paper surfaces were inoculated into guinea pigs of which not a single animal developed tuberculosis. Other experiments of this kind point to the conclusion that while the risk of infection from books is not to be belittled, the possibility of transmission from such channels is extremely small.

The present authors permitted certain patients with advanced pulmonary tuberculosis, with uncontrollable cough and with sputum of Gaffky 6 to 8, to handle books as carelessly as possible. They coughed on the marked pages, and wet their thumbs with saliva when turning these pages. Scrapings later derived from the marked pages were collected and suspended in physiological salt solution. Tuberculin negative guinea pigs were

inoculated with this solution. Three of the 16 guinea pigs died from intercurrent disease and no evidence of tuberculosis could be found at the postmortem. The remaining 13 remained tuberculin negative 92 days after the inoculation, when they were sacrificed.

Another set of experiments demonstrated that the dust collected by scrapings from garments worn by patients with open tuberculosis would not infect guinea pigs. However, this failure should not give rise to a sense of false security and to a laxity of precautionary measures. The summary includes the following suggestions:

a. It seems at the present time, the best way to ease the mind of the possibility of transmission by a book which has been handled by a patient with open tuberculosis, is to store or quarantine the book for several weeks until the morbid material has completely dried, as it has been shown repeatedly that the drying robs the bacilli of their power of producing disease in animals. This measure was recommended by British Joint Tuberculosis Commission.

b. We have no suggestion of importance to make as to how the patients' garments should be disinfected. Perhaps the safest way is to expose them to the sun and air for a few days before storing away.

*The Occurrence of Tubercle Bacilli on Garments and Books Handled by Patients with Open Tuberculosis*, M. A. Jacobs, M.D., and S. A. Petroff, Ph.D., *Quarterly Bull. Sea View Hosp.*, Oct., 1941.

## TUBERCLE BACILLI IN THE HOSPITAL ROOM

Cultures were made from swabbings of bedside tables, lamps, bed frames and other articles in rooms occupied by patients at Barlow Sanatorium, also from room dust and sweepings and from cotton filters through which room air had been sucked. Uniformly negative results led to speculation as to the effect of daytime roomlight on living tubercle bacilli.

Review of the literature seems to sustain the statement of Park and Williams that: "Tubercle bacilli in sputum when exposed to direct sunlight are killed in from a few minutes to several hours according to the thickness of the layer and the season of the year. They are usually destroyed by diffuse daylight in from five to ten days. Dried sputum in rooms protected from abundant light has occasionally been found to contain virulent tubercle bacilli for as long as ten months."

For the present experiment, suspensions of virulent human tubercle bacilli in water or in sputum were spread on cover slips in 0.05 cc. amounts and allowed to dry. Some of these preparations were placed in a small unheated room in the light of an unglazed but screened north window through which the sun was known never to shine; others were kept in complete darkness within a cardboard box inside a second such box which in turn was kept in a table drawer of an unheated room. This was done during a clear, dry period in mid-winter at Los Angeles. (Technics are described in detail.)

A second set of tests was run in the early spring during cloudy and rainy weather and a third set of tests in mid-summer. The following winter, viability was tested also in the electric refrigerator.

The viability of tubercle bacilli was determined by animal inoculation and by culture.

1. Dried tubercle bacilli survived unfiltered north roomlight from four hours to five days under varying conditions. They were non-viable, according to the methods of recovery used, at one to twelve days; not established in one case.

2. Viability in the dark was from less than forty days to between three and one-half and five months.

3. Viability in the refrigerator was between six and one-half and fourteen months.

4. Tubercle bacilli were more readily recoverable and after longer periods of exposure when the dose deposited was larger.

5. They lived longer in smears made from sputum than from water suspensions.

6. They lived longer in the winter than in the spring and summer.

7. Variations in relative humidity and periods of partial cloudiness had no effect on viability.

8. Unfiltered daytime roomlight probably plays a very important role in preventing cross-infection and in protecting the employees of tuberculosis sanatoria.

*Survival of Tubercle Bacilli, C. Richard Smith, M.D., Amer. Rev. of Tuberc., March, 1941.*

## TUBERCLE BACILLI IN THE AUTOPSY ROOM

Two incidents seem to have prompted this study: The isolation of acid-fast organisms from the surface of eyeglasses worn during an autopsy on an active case of tuberculosis; and the observation that the incidence of tuberculosis among medical students appears to be proportional to their contact with autopsy material during the second year in medical school. The compression of the crepitant lung, causing expulsion of minute amounts of bacteria-laden air, might simulate a human cough and thus be responsible for the dissemination of bacteria.

Lungs from patients who died from tuberculosis were sectioned in the usual manner, the trachea was opened, regional lymph nodes were examined and all cavities were opened with scissors.

This was done under a shield, equipped with a glass plate situated eight inches directly above the specimen. After a 15 minute examining period the plate was washed with sterile saline solution.

The growths which were obtained from the washings lead to the conclusion that methods of examination which make use of a compression technic contaminate the atmosphere in the vicinity of the autopsy and that fresh tuberculous lungs are decidedly dangerous, and are a potent source of atmospheric contamination against which methods of proper protection should be devised.

*The Dissemination of Tubercle Bacilli from Fresh Autopsy Material, Ruell A. Sloan, M.D., N. Y. State Jour. of Med., Jan. 15, 1942.*

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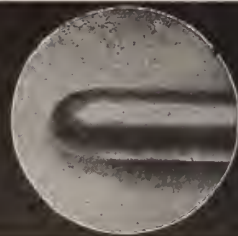
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1. 1766—Robert McKean, Perth Amboy, 1732-1767	37. 1822—Augustus R. Taylor, Somerville, 1782-1840
2. 1767—William Burnet, Newark, 1730-1791	38. 1823—William B. Ewing, Greenwich, 1776-1866
3. 1768—John Cochran, New Brunswick, 1730-1807	39. 1824—Peter I. Stryker, No. 24 and 32 reelected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781	40. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
5. 1771—Isaac Smith, Trenton, 1740-1807	41. 1826—William D. McKissack, Millstone, 1781-1853
6. 1772—James Newell, Freehold, 1725-1791	42. 1827—Isaac Pierson, Orange, 1770-1833
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807	43. 1828—Jephtha B. Munn, Chatham, 1780-1863
8. 1774—Thomas Wiggins, Princeton, 1731-1801	44. 1829—John W. Craig, Somerset County, 1795-1871
9. 1775—Hezekiah Stites, Cranbury, 1726-1790	45. 1830—Augustus R. Taylor, No. 37 reelected
No formal meetings 1776-1780 on account of the War of the Revolution.	
10. 1781—James Newell, No. 6 reelected	46. 1831—Thomas Yarrow, Sharptown, 1773-1841
11. 1782—John Beatty, Trenton, 1749-1826	47. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
12. 1783—Thomas Barber, Matawan, 1730-1807	48. 1833—William Forman, Monmouth County, 1796-1848
13. 1784—Lawrence Vander Veer, Roycefield, 1740-1815	49. 1834—Samuel Hayes, Newark, 1776-1839
14. 1785—Moses Bloomfield, Woodbridge, 1729-1791	50. 1835—Abraham P. Hagerman, Somerset County
15. 1786—William Burnet, No. 2 reelected	51. 1836—Henry Vander Veer, Somerville, 1792-1874
16. 1787—Jonathan Elmer, Bridgeton, 1745-1817	52. 1837—Lyndon A. Smith, Newark, 1795-1865
17. 1788—James Stratton, Swedesboro, 1755-1812	53. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
18. 1789—Moses Scott, New Brunswick, 1733-1821	54. 1839—Jabez G. Goble, Newark, 1799-1859
19. 1790—John Griffith, Rahway, 1736-1805	55. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
20. 1791—Lewis Dunham, New Brunswick, 1754-1821	56. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
21. 1792—Isaac Harris, Middlesex County, 1741-1808	57. 1842—Zachariah Read, Mt. Holly, 1808-1879
22. 1795—Elisha Newell, Allentown, 1755-1799	58. 1843—Abraham Skillman, Bound Brook, 1796-1862
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23. 1807—Jonathan F. Morris, Somerville, 1760-1810	59. 1844—George R. Chetwood, Elizabeth, 1802-1835
24. 1808—Peter I. Stryker, Somerville, 1766-1859	60. 1845—Robert S. Smith, Bound Brook, 1800-1874
25. 1809—Lewis Morgan, Rahway, 1757-1821	61. 1846—Charles Hannah, Deerfield, 1782-1857
26. 1810—Lewis Condict, Morristown, 1773-1862	62. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
27. 1811—Charles Smith, New Brunswick, 1768-1848	63. 1848—Samuel Hayes Pennington, Newark, 1806-1900
28. 1812—Matthias H. Williamson, Elizabeth. Served two years.	64. 1849—Joseph Fithian, Woodbury, 1795-1881
29. 1814—Samuel Forman, Freehold, 1764-1845	65. 1850—Elias J. Marsh, Paterson, 1803-1850
30. 1815—John Van Cleve, Princeton, 1778-1826	66. 1851—John H. Phillips, Pennington, 1814-1875
31. 1816—Lewis Dunham, No. 20 reelected	67. 1852—Othneil H. Taylor, Camden, 1803-1869
32. 1817—Peter I. Stryker, No. 24 reelected	68. 1853—Samuel Lilly, Lambertville, 1815-1880
33. 1818—John Van Cleve, No. 30 reelected	69. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
34. 1819—Lewis Condict, No. 26 reelected	70. 1855—James B. Coleman, Trenton, 1806-1877
35. 1820—James Lee, Newark	71. 1856—Richard M. Cooper, Camden, 1816-1874
36. 1821—William G. Reynolds, Manalapan	



- | Year of<br>Election |   | Year of<br>Election |  |
|---------------------|---|---------------------|--|
| 72.                 | 1857—Thomas Ryerson, Newton, 1821-1887                | 117.                | 1902—Edward L. B. Godfrey, Camden,<br>1850-1913                  |
| 73.                 | 1858—Isaac Pierson Coleman, Pemberton,<br>1804-1869   | 118.                | 1903—Henry Mitchell, Asbury Park, 1845-1919                      |
| 74.                 | 1859—John R. Sickler, Mantua, 1800-1886               | 119.                | 1904—Walter B. Johnson, Paterson, 1852-1922                      |
| 75.                 | 1860—William Elmer, Bridgeton, 1814-1889              | 120.                | 1905—Henry W. Elmer, Bridgeton, 1847-1907                        |
| 76.                 | 1861—John Blane, Perryville, 1802-1885                | 121.                | 1906—Alexander Marcy, Jr., Riverton,<br>1860-1934                |
| 77.                 | 1862—John Woolverton, Trenton, 1825-1888              | 122.                | 1907— <b>EDWARD J. ILL</b> , Newark, born 1854                   |
| 78.                 | 1863—Theodore R. Varick, Jersey City,<br>1825-1887    | 123.                | 1908—David St. John, Hackensack, 1850-1917                       |
| 79.                 | 1864—Ezra M. Hunt, Metuchen, 1830-1894                | 124.                | 1909—Benjamin A. Waddington, Salem,<br>1842-1917                 |
| 80.                 | 1865—Abraham Coles, Newark, 1813-1891                 | 125.                | 1910—Thomas H. MacKenzie, Trenton,<br>1847-1920                  |
| 81.                 | 1866—Benjamin R. Bateman, Bridgeton,<br>1807-1883     | 126.                | 1911—David Strock, Camden, 1850-1927                             |
| 82.                 | 1867—John C. Johnson, Blairstown, 1828-1907           | 127.                | 1912—Norton L. Wilson, Elizabeth, 1861-1931                      |
| 83.                 | 1868—Thomas J. Corson, Trenton, 1828-1879             | 128.                | 1913—Enoch Hollingshead, Pemberton,<br>1843-1924                 |
| 84.                 | 1869—William Pierson, Orange, 1796-1882               | 129.                | 1914—Frank D. Gray, Jersey City, 1857-1916                       |
| 85.                 | 1870—Thomas F. Cullen, Camden, 1822-1877              | 130.                | 1915—William J. Chandler, South Orange,<br>1842-1927             |
| 86.                 | 1871—Charles Hasbrouck, Hackensack,<br>1818-1877      | 131.                | 1916—Philip Marvel, Atlantic City, 1856-1938                     |
| 87.                 | 1872—Franklin Gauntt, Burlington, 1823-1900           | 132.                | 1917—William G. Schauffler, Lakewood,<br>1862-1933               |
| 88.                 | 1873—Thomas J. Thomason, Perrineville,<br>1833-1880   | 133.                | 1918—Thomas W. Harvey, Orange, 1853-1938                         |
| 89.                 | 1874—George H. Larison, Lambertville,<br>1831-1892    | 134.                | 1919—Gordon K. Dickinson, Jersey City,<br>1855-1930              |
| 90.                 | 1875—William O'Gorman, Newark, 1824-1887              | 135.                | 1920—Philander A. Harris, Paterson, 1852-1924                    |
| 91.                 | 1876—John V. Schenck, Camden, 1825-1882               | 136.                | 1921—Henry B. Costill, Trenton, 1860-1935                        |
| 92.                 | 1877—Henry R. Baldwin, New Brunswick,<br>1829-1902    | 137.                | 1922—James Hunter, Jr., Westville, 1866-1931                     |
| 93.                 | 1878—John S. Cook, Hackettstown, 1827-1900            | 138.                | 1923— <b>WELLS P. EAGLETON</b> , Newark,<br>born 1865            |
| 94.                 | 1879—Alexander W. Rogers, Paterson,<br>1814-1905      | 139.                | 1924—Archibald Mercer, Newark, 1849-1931                         |
| 95.                 | 1880—Alexander N. Dougherty, Newark,<br>1822-1882     | 140.                | 1925— <b>LUCIUS DONOHUE</b> , Bayonne, born<br>1868              |
| 96.                 | 1881—Lewis W. Oakley, Elizabeth, 1828-1888            | 141.                | 1926—James S. Green, Jr., Elizabeth, 1864-1936                   |
| 97.                 | 1882—John W. Snowden, Blackwood, 1823-1888            | 142.                | 1927— <b>WALT P. CONAWAY</b> , Atlantic City,<br>born 1873       |
| 98.                 | 1883—Stephen Wickes, Orange, 1813-1889                | 143.                | 1928—Ephraim R. Mulford, Burlington,<br>1880-1939                |
| 99.                 | 1884—Phanett C. Barker, Morristown,<br>1835-1903      | 144.                | 1929— <b>ANDREW F. McBRIDE</b> , Paterson,<br>born 1869          |
| 100.                | 1885—Joseph Parrish, Burlington, 1818-1891            | 145.                | 1930— <b>GEORGE N. J. SOMMER</b> , Trenton,<br>born 1874         |
| 101.                | 1886—Charles J. Kipp, Newark, 1838-1911               | 146.                | 1931—John F. Hagerty, Newark, 1869-1937                          |
| 102.                | 1887—John W. Ward, Trenton, 1840-1916                 | 147.                | 1932—A. Haines Lippincott, Camden, 1867-1937                     |
| 103.                | 1888—H. Genet Taylor, Camden, 1837-1916               | 148.                | 1933— <b>FREDERIC J. QUIGLEY</b> , Union City,<br>born 1883      |
| 104.                | 1889—Beriah A. Watson, Jersey City,<br>1836-1892      | 149.                | 1934— <b>LANCELOT ELX</b> , born 1875                            |
| 105.                | 1890—James S. Green, Elizabeth, 1829-1892             | 150.                | 1935— <b>MARCUS W. NEWCOMB</b> , Brown's<br>Mills, born 1880     |
| 106.                | 1891—Elias J. Marsh, Jr., Paterson,<br>1835-1908      | 151.                | 1936—Francis R. Haussling, Newark, 1875-1941<br>—resigned        |
| 107.                | 1892—George T. Welch, Passaic, 1845-1924              | 152.                | 1936— <b>SPENCER T. SNEDECOR</b> , Hacken-<br>sack, born 1900    |
| 108.                | 1893—John G. Ryerson, Boonton, 1834-1916              | 153.                | 1937— <b>WILLIAM G. HERRMAN</b> , Asbury<br>Park, born 1890      |
| 109.                | 1894—Obadiah H. Sproul, Flemington,<br>1844-1925      | 154.                | 1938— <b>WILLIAM J. CARRINGTON</b> , Atlantic<br>City, born 1884 |
| 110.                | 1895—William Elmer, Trenton, 1840-1908                | 155.                | 1939— <b>E. ZEH HAWKES</b> , Newark, born 1865                   |
| 111.                | 1896—Thomas J. Smith, Brigeton, 1841-1932             | 156.                | 1940— <b>WATSON B. MORRIS</b> , Springfield,<br>born 1878        |
| 112.                | 1897—David C. English, New Brunswick,<br>1842-1924    | 157.                | 1941— <b>THOMAS K. LEWIS</b> , Camden, born<br>1887              |
| 113.                | 1898—Claudius R. P. Fisher, Bound Brook,<br>1859-1927 |                     |  |
| 114.                | 1899—Luther M. Halsey, Williamstown,<br>1858-1921     |                     |  |
| 115.                | 1900—William Pierson, Jr., Orange, 1830-1900          |                     |  |
| 116.                | 1901—John D. McGill, Jersey City, 1846-1912           |                     |  |

The names of living Fellows are in bold face type.

## HONORARY MEMBERS

- | Year of<br>Election |  | Year of<br>Election |  |
|---------------------|--|---------------------|--|
| 1.                  | 1916—George W. Crile, Cleveland, 1864    | 5.                  | 1936—Andrew F. McBride, Paterson, 1869   |
| 2.                  | 1925—Edward J. Ill, Newark, 1854         | 6.                  | 1939—Nathan B. Van Etten, New York, 1866 |
| 3.                  | 1930—Joseph E. Raycroft, Princeton, 1867 | 7.                  | 1939—Haven Emerson, New York, 1874       |
| 4.                  | 1935—Wells P. Eagleton, Newark, 1865     | 8.                  | 1940—James Ewing, New York, 1866         |

# An Alphabetical List of the Members of The Medical Society of New Jersey

COMPILED MARCH 15, 1942

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

## A

### ACTIVE MEMBERS

- |                           |                              |                             |
|---------------------------|------------------------------|-----------------------------|
| Abel, Arthur R. (7)       | Allegrante, Anthony J. (18)  | Appleton, Ralph (15)        |
| Abel, Henri E. (20)       | Allen, Chester B., Jr. (7)   | Appold, George D. (2)       |
| Abey, William J. H. (11)  | Allen, G. Herbert (7)        | Apter, Abraham H. (16)      |
| Abrams, Abram B. (7)      | Allen, Isaac L. (9)          | Arbeit, Sidney R. (9)       |
| Abramson, Solomon (20)    | Allen, James M. (16)         | Areson, William H. (7)      |
| Ackerhalt, Martin J. (16) | Alling, Frederic A. (7)      | Aria, Charles (9)           |
| Ackerman, Arthur F. (20)  | Allman, David B. (1)         | Aria, Michael H. (9)        |
| Ackermann, Edward (14)    | Alpert, Edward (9)           | Armstrong, Lorrimer B. (20) |
| Ackley, David B. (11)     | Alpren, Bernard F. (16)      | Armstrong, Robert R. (16)   |
| Adams, Rayford K. (18)    | Alter, Nicholas M. (9)       | Arndt, Frank R. (9)         |
| Adelman, Benjamin B. (7)  | Altman, Charles D. (7)       | Aronis, Harry R. (11)       |
| Adler, Joseph (9)         | Altschul, Frank J. (13)      | Aronowitz, Harry T. (9)     |
| Africano, Julius V. (9)   | Ambrose, Anthony (7)         | Arons, Harry (7)            |
| Agayoff, John D. (2)      | Ambrose, Robert R. (18)      | 'Artaserse, George V. (9)   |
| Agnew, Hobart M. (7)      | Amdur, Louis A. (9)          | Arthur, Frances H. (20)     |
| Agolia, Michael W. (9)    | Anderson, John F. (12)       | Asbell, Nathan (4)          |
| Ainsley, H. Bryson (9)    | Anderson, Reuben M. (2)      | Ash, Arthur F. (9)          |
| Aitken, Frank J. (6)      | Anderson, Richard D. (3)     | Ash, Frank W. (16)          |
| Aitken, Herbert M. (19)   | Anderson, William A. (7)     | Ash, Samuel (7)             |
| Albano, Edwin H. (7)      | Anderson, William M. (4)     | Asher, Maurice (7)          |
| Albano, Frank J. (7)      | Andrews, Clarence L. (1)     | Ashley, Harmon H. (11)      |
| Albano, Joseph (7)        | Andrus, David L. (4)         | Aszody, Paul (7)            |
| Albert, Perry (11)        | Angelillis, Paul (2)         | Athey, Kenneth L. (4)       |
| Albrecht, William J. (18) | Angelillo, Marc C. (7)       | Atkinson, James W. (16)     |
| Albright, Louis F. (13)   | Angelo, Joseph A. (9)        | Atwell, David R. (9)        |
| Alcamo, John H. (7)       | Angiolitti, Louis V. (2)     | Atwood, Edward A. (16)      |
| Alcaro, Joseph A. (14)    | Anrig, Grace E. (9)          | Auremma, Michele (9)        |
| Alexander, Samuel (2)     | Anson, Leon J. (20)          | Austin, Henry J. (11)       |
| Alexander, Stewart F. (2) | Antonius, Nicholas A. (7)    | Austin, Thomas R. (20)      |
| Alexander, Walter G. (7)  | Anuario, Charles B. (7)      | Averbach, Jacob (16)        |
| Alford, Ralph I. (7)      | Applebaum, Irving L. (7)     | Avery, Philip S. (12)       |
| Allan, James S. (7)       | Applegate, Edward T. R. (11) | Axilrod, Maurice H. (1)     |
|                           | Applestein, Robert (11)      |                             |

### ASSOCIATE MEMBERS

- |                     |                    |
|---------------------|--------------------|
| Adelman, Nathan (7) | Asten, George (16) |
|---------------------|--------------------|

## B

### ACTIVE MEMBERS

- |                            |                          |                           |
|----------------------------|--------------------------|---------------------------|
| Babbitt, Hugh M., Jr. (20) | Baker, Augustus L. (14)  | Baldauf, Herman, Jr. (21) |
| Bachmann, Wm. (7)          | Baker, Banks S. (4)      | Baldwin, John F. (2)      |
| Bacon, Mary (6)            | Baker, Charles F. (7)    | Baldwin, Samuel H. (7)    |
| Bacote, Ernest F. (7)      | Baker, Elsworth F. (13)  | Ballinger, Reeve L. (9)   |
| Baeseman, R. Winfield (13) | Baker, Hugh W. (6)       | Balogh, William A. (12)   |
| Bagg, Linus W. (7)         | Baker, Maclyn F. (7)     | Balsamo, Anthony J. (9)   |
| Bahnson, Conrad M. (9)     | Baker, Maurice E. (4)    | Balze, Henry R. (2)       |
| Bailyn, Emanuel (9)        | Baker, Philip W. (10)    | Bambara, Aurelius J. (10) |
| Baiocchi, Pascal J. (7)    | Baker, Raymond D. (20)   | Banker, George T. (20)    |
| Baird, Thompson M. (7)     | Baketel, H. Sheridan (2) | Banta, Raymond E. (2)     |

- Bar, Samuel (13)  
 Barb, Kirk B. (4)  
 Barbarito, Wm. N. (9)  
 Barbash, Roslyn H. W. (2)  
 Barbash, Samuel (1)  
 Barbello, Joseph D. (7)  
 Barbour, George E. (18)  
 Barishaw, Samuel B. (9)  
 Barkhorn, Charles W. (7)  
 Barkhorn, Henry C. (7)  
 Barlow, Frank A. (16)  
 Barlow, G. Barton (2)  
 Barnard, Frank G. (7)  
 Barnes, William J. (2)  
 Barnshaw, Harold D. (4)  
 Barolsky, Benjamin (16)  
 Baron, Herbert A. (2)  
 Baron, Leo E. (20)  
 Barone, Francis A. (9)  
 Barr, Joseph, (16)  
 Barrett, John E. (7)  
 Barrett, Joseph F. (7)  
 Barroway, James N. (4)  
 Barrows, Arthur M. (11)  
 Barrows, Victor J. (8)  
 Barry, R. Grant (11)  
 Bartlett, Clara K. (1)  
 Baruch, Hilde (20)  
 Baruch, Rudolf J. (20)  
 Basrallian, Joseph B. (2)  
 Bass, Rose D. (7)  
 Bassett, Lavern C. (12)  
 Bassett, Norman H. (1)  
 Baum, Felix (7)  
 Baum, Samuel (7)  
 Bauman, Everett O. (7)  
 Bauman, Kenneth R. (6)  
 Bauman, Rush C. (7)  
 Baxt, Sidney J. (16)  
 Bayne, Joseph K. (11)  
 Beairsto, Everett B. (11)  
 Beatty, Hannah J. (10)  
 Beaver, Jennie D. (14)  
 Becker, C. Frederick (4)  
 Becker, Frank F. (16)  
 Becker, Frederick W. (7)  
 Becker, George L. (16)  
 Becker, Leo V. (16)  
 Becker, Martin (7)  
 Becker, Sidney D. (13)  
 Becket, George C. (7)  
 Behrens, Herman H. E. (9)  
 Beideman, Casper M. (4)  
 Beir, Ily R. (1)  
 Beisler, Lawrence G. (20)  
 Belafsky, Henry A. (12)  
 Belfer, Jacob J. (11)  
 Belford, Ralph J. (11)  
 Beling, C. Abbott (7)  
 Beling, Christopher C. (7)  
 Bell, Horace O. (7)  
 Bell, Thomas (7)  
 Bellak, Ellis R. (6)  
 Bellina, George L. (9)  
 Bellis, Horace D. (11)  
 Ben-Asher, Solomon (9)  
 Bender, Dorothea A. (20)  
 Bender, Max (9)  
 Bender, Theodore (16)  
 Bendix, Gerhard M. (18)  
 Benedict, Alfred C. (7)  
 Bengelsdorf, Aron (7)  
 Benjamin, Harold C. (9)  
 Bennett, Robert E. (11)  
 Bennett, Samuel D. (6)  
 Bennett, William F. (7)  
 Bensley, Maynard G. (20)  
 Bentley, David F., Jr. (4)  
 Berardinelli, Carmine G. (7)  
 Berenson, Samuel J. (20)  
 Beres, Albert J. (2)  
 Berg, Samuel (7)  
 Berger, William A. (7)  
 Bergin, Joseph V. (16)  
 Bergman, Meyer W. (7)  
 Bergmann, Ewald H. (19)  
 Bergmeyer, Josef T. (9)  
 Bergsma, Daniel (11)  
 Berk, M. David (16)  
 Berke, Raynold N. (2)  
 Berkhout, Peter G. (16)  
 Berkow, Samuel G. (12)  
 Berkowitz, Benj. (6)  
 Berlin, Joseph I. (9)  
 Berman, H. Robert (7)  
 Berman, Jacob J. (11)  
 Berman, Leonard M. (20)  
 Berman, Sol (20)  
 Bernard, Richard C. (2)  
 Bernhard, William G. (7)  
 Bernheisel, Louis E. (5)  
 Bernstein, Arthur (7)  
 Bernstein, Benedict J. (20)  
 Bernstein, Julius (7)  
 Berry, C. Hartley (20)  
 Berry, Leonard M. (11)  
 Bertha, Nicholas A. (14)  
 Beshlian, Hagop K. (16)  
 Besson, Franklin J. (7)  
 Betancourt, Raul R. (4)  
 Betcher, Albert (9)  
 Betts, R. Winfield (3)  
 Beveridge, William W. (13)  
 Bew, Richard C. (1)  
 Beyer, Othmar J. (7)  
 Beyer, William, Jr. (2)  
 Bianchi, Angelo R. (7)  
 Bickner, Alvah W. (2)  
 Biczak, Arkad K. (16)  
 Bien, Frank A. (7)  
 Bierach, Jules L. (15)  
 Bigelow, Elizabeth F. (7)  
 Bigelow, Nelson S. (7)  
 Bigliani, Urban R. (9)  
 Binder, Joseph (13)  
 Bingham, Arthur W. (7)  
 Bird, Frank L. (14)  
 Birdsall, Clarence A. (7)  
 Birrell, Russell G. (20)  
 Bishop, Carl (20)  
 Bissett, John V. (7)  
 Bitten, Robert M. (9)  
 Blunno, Anthony J. (7)  
 Black, LeRoy W. (2)  
 Black, Maskell B. (8)  
 Black, Max S. (20)  
 Blackwell, Enoch (11)  
 Blair, Thomas D. (20)  
 Blaisdell, C. Byron (13)  
 Blake, Albert J. (16)  
 Blakey, Abram P. (9)  
 Blanchard, Charles L. (14)  
 Blank, Samuel (18)  
 Blatt, David (20)  
 Blaugrund, Samuel (11)  
 Blaustein, Maurice L. (7)  
 Blauvelt-Wells, Grace B. (2)  
 Bleasby, Charles B. (2)  
 Bleiberg, Jacob (7)  
 Blenkle, Victor A. (2)  
 Bloch, Harry (20)  
 Block, Marcus T. (7)  
 Block, Max (7)  
 Block, Milton (7)  
 Blum, Joseph M. (11)  
 Blum, Milton (9)  
 Blumberg, A. William (15)  
 Blumberg, Jack (20)  
 Blythe, Rowland P. (20)  
 Bobadilla, Juan E. B. (14)  
 Bocchini, Joseph A. (7)  
 Bohl, Louis J. (16)  
 Boland, Lucy E. (9)  
 Bolanowski, Kasimier J. (20)  
 Bolten, Bernard (7)  
 Bonanno, Peter J. (9)  
 Bongiorno, Henry D. (16)  
 Bonnet, W. Laurence (11)  
 Bono, Joseph J. (2)  
 Bonomo, Michael J. (7)  
 Bonyng, Henry A. (16)  
 Bookrajan, Edward N. (9)  
 Bookstaver, Barnet S. (2)  
 Booth, George R. (8)  
 Booth, Walter S. (20)  
 Booth, William K. (14)  
 Boothby, I. Roland (10)  
 Boozan, William E. (20)  
 Boquist, Walter A. (21)  
 Bornstein, David (16)  
 Bornstein, Paul K. (13)  
 Borow, Benjamin (18)  
 Borow, Henry (18)  
 Borow, Louis S. (18)  
 Borow, Maurice (18)  
 Borrella, Dominic D. (11)  
 Borrone, Milton G. (9)  
 Borshaw, Hyman (9)  
 Borsher, Irving P. (7)  
 Bortone, Frank (9)  
 Bosch, Taeke (2)  
 Boselli, Emil H. (9)  
 Bossard, Harry B. (21)  
 Bostwick, Delazon S. (6)  
 Bostwick, Wallace R. (21)  
 Botbyl, Burt W. (16)  
 Botti, John A. (9)  
 Bourns, Edward G. (20)  
 Bove, Joseph (7)  
 Bowers, F. Clyde (14)  
 Bowersox, Clarence A. (8)  
 Bowles, Harry H. (20)  
 Bowman, Ned O. (12)  
 Boyd, John B. (13)  
 Boyd, Robert P. (20)  
 Boyer, Charles G. (10)  
 Boyer, Paul K. (20)  
 Boyers, Sidney S. (9)  
 Boyes, James G. (20)  
 Boylan, Lawrence B. (16)  
 Boyle, Francis L. (9)  
 Boysen, Theophilus H. (1)  
 Brackett, Elizabeth R. (7)  
 Bradasch, George A. (9)  
 Bradford, Stella S. (7)  
 Bradley, Robert A. (1)  
 Bradshaw, John H. (7)  
 Brady, Thomas S. (9)  
 Brady, William A. (9)  
 Braitman, Max (9)  
 Brakeley, Elizabeth (7)  
 Bramble, Halsey S. (17)  
 Brancato, Peter (16)  
 Brandman, Otto (7)  
 Branin, Howard S. (6)



Branon, Mark E. (2)  
Brasefield, Edgar N. (21)  
Brauer, Selig L. (9)  
Braun, David C. (19)  
Braun, Gustav A. (7)  
Braun, William (4)  
Braunstein, Sigmund C. (9)  
Braunstein, William P. (9)  
Bray, William E. (3)  
Bregman, Alexander (2)  
Breitstadt, Charles A. (7)  
Brennan, Alfred T. V., Jr. (2)  
Brennan, Charles L. S. (4)  
Brennan, John P. (4)  
Brennock, Thomas McG. (9)  
Bresev, Morris (9)  
Breslow, Alexander E. (20)  
Breslow, Samuel (12)  
Brethwaite, Samuel H., Jr. (20)  
Brick, George J. (9)  
Brien, William M. (7)  
Briggs, Henry (7)  
Brignola, Gerald C. (9)  
Brim, Anne S. (7)  
Brindle, Harry R. (13)  
Brittain, Elmore G. (18)  
Broadnax, Mary E. (7)  
Brock, H. F. (20)  
Brodkin, Eva T. (7)  
Brodkin, Henry A. (7)  
Brodkin, Louis A. (7)  
Brody, Morton S. (12)  
Brogan, Francis B. (16)  
Brokaw, Christopher A. (20)  
Bromberg, Charles B. (16)

Brooks, George M. (5)  
Brooks, Sidney S. (16)  
Brophy, Francis X. (9)  
Broselow, Benjamin G. (8)  
Brotman, Morton M. (7)  
Brown, Chester R. (7)  
Brown, Chester T. (7)  
Brown, Edith L. (13)  
Brown, Frederick L. (12)  
Brown, Harold W. (7)  
Brown, Harvey S. (13)  
Brown, J. Carlisle (1)  
Brown, John L. (2)  
Brown, Kenneth G. (13)  
Brown, L. Greeley (20)  
Brown, Leonard (2)  
Brown, Lewis W. (7)  
Brown, Stanley L. (4)  
Brown, William H. (20)  
Browning, William J. (4)  
Brozdowski, John J. (9)  
Bruning, Richard H. (7)  
Buchanan, Ralph M. L. (21)  
Buckley, Jeremiah L. (7)  
Buckley, Paul J. (2)  
Buckley, Richard T., Jr. (11)  
Budd, J. Reuben (16)  
Buermann, Robert (15)  
Bull, Louis M. (7)  
Bull, Robert I. (7)  
Bull, William J. (7)  
Bullen, Victor E. (16)  
Bullwinkel, Frederick (13)  
Bump, Samuel C. (2)  
Bunnell, Frederick N. (15)  
Burbidge, J. Raymond (11)

Burke, Leonard P. (7)  
Burke, Stephen E. (7)  
Burkett, J. Paul (8)  
Burkett, Wendell J. (8)  
Burn, Victor E. (19)  
Burne, John J. (7)  
Burnett, Charles B. (12)  
Burnham, Lyman (2)  
Burns, Geoffrey C. H. (2)  
Burns, Joseph R. (11)  
Burns, Wilmer F. (4)  
Burpeau, William P. (7)  
Burrill, Benj. B., Jr. (7)  
Burritt, Norman W. (20)  
Burroughs, Edmund W. (11)  
Burrus, Thomas P. (7)  
Burstein, Frank (7)  
Busansky, Samuel T. (3)  
Busch, Herman (7)  
Bush, Archer C. (7)  
Bush, Ralph K. (4)  
Busicco, Philip S. (2)  
Butan, Louis (7)  
Butcher, Charles (6)  
Butenas, Joseph J. (20)  
Butler, Eustace C. (7)  
Butler, Vincent P. (9)  
Butterfield, Arey A. (16)  
Buvinger, Charles W. (7)  
Buzby, B. Franklin (4)  
Byck, Louis (7)  
Byer, M. Yale (11)  
Byrne, J. Arthur (14)  
Byrnes, Elizabeth W. (7)  
Bythewood, Alton E., Jr. (7)

#### ASSOCIATE MEMBERS

Baime, Jules E. (7)  
Balsamo, Joseph J. (7)  
Barbano, Alfred J. (12)  
Barnett, Lester A. (12)

Bases, Leonard (13)  
Bender, Louis (7)  
Berlin, Morris R. (7)  
Binder, Israel L. (7)

Boyt, Theodore (12)  
Braun, Edgar M. (7)  
Bremer, Kenneth M. (7)  
Burstein, Leo Q. (7)

## C

#### ACTIVE MEMBERS

Cacciarelli, Robert A. (7)  
Caggiano, Anthony P. (7)  
Caggiano, John D. (17)  
Cahill, Laurence A. (7)  
Calabrese, D. John (2)  
Caldwell, Donald M. (7)  
Caleca, Jack J. (19)  
Callahan, Edward J. (20)  
Calligaro, Egildo A. (16)  
Calvert, William C. (7)  
Calvin, Charles H. (12)  
Camche, Leo J. (7)  
Cameron, Arthur E. (7)  
Cameron, C. Paul (5)  
Cameron, Edwin A. (7)  
Campana, Vincent R. (9)  
Campbell, James M. (2)  
Campbell, William (7)  
Campbell, William K. (13)  
Campo, A. Guy (8)  
Candio, Vincent P. (2)  
Cannon, Edward A. (9)  
Canright, Cyril M. (20)  
Cantalupo, Emidio (7)  
Cantini, Raphael S. (20)

Canuso, Nicholas A. (4)  
Capell, Harry H. (16)  
Capitanian, Aram A. (13)  
Caputo, Anthony R. (7)  
Carabelli, A. Albert (11)  
Carberry, Edward T. (14)  
Carbone, Francesco N. (7)  
Carbone, Ralph (2)  
Card, Charles F. (20)  
Cardinale, Pasquale F. (20)  
Cardwell, Edgar P. (7)  
Carey, David S. (13)  
Caridi, Salvatore (9)  
Carlander, Oswald R. (4)  
Carlisle, J. Mallory (20)  
Carlisle, John H. (16)  
Carlisle, Paul E. (7)  
Carlough, David J. (16)  
Carman, Fletcher F. (7)  
Carmona, L. Roberto (15)  
Carpenter, Cedric C. (20)  
Carpenter, Charles A. (7)  
Carpenter, William H. (8)  
Carr, Mary B. (9)  
Carrigan, Francis P. (7)

Carrington, William J. (1)  
Carrol, Wilfred (7)  
Carroll, C. Walter (11)  
Carroll, Thomas R. (2)  
Carroll, William V. (11)  
Carsley, Sidney H. (20)  
Carter, Joseph F. S. (13)  
Cartnick, Louis C. (2)  
Caruso, Paul F. (2)  
Casale, John B. (7)  
Casciano, Adolph D. (2)  
Casilli, Arturo R. (20)  
Casselman, Arthur J. (4)  
Castaldo, Neil (20)  
Castellano, Martin G. (7)  
Catania, Joseph P. (2)  
Catanzaro, Francesco (16)  
Cater, Douglas A. (7)  
Catlaw, J. Kenneth (9)  
Cella, Charles F. (11)  
Cerone, Daniel M. (7)  
Cestone, Canio (7)  
Chaiken, Louis H. (20)  
Chalfant, W. Paxson, Jr. (1)  
Chalfant, William P. (8)

- Chamberlain, Aims R. (7)  
 Chamberlain, Richard R. (7)  
 Champlin, Paul M. (7)  
 Chapman, Ellis J. (9)  
 Chapman, Otis P. (20)  
 Chapman, Robert W. (7)  
 Chapman, Walter I. (16)  
 Chapnick, Maurice M. (16)  
 Charleroy, Durant K. (11)  
 Charlton, C. Coulter (1)  
 Charney, William (16)  
 Chase, Kalman, Jr. (2)  
 Chayes, Sydney (9)  
 Chernus, Jack (7)  
 Cherry, Homer H. (16)  
 Chesler, Maurice (17)  
 Chesner, William A. (11)  
 Chesnick, Reuben B. (4)  
 Chester, Saul W. (16)  
 Chianese, C. Chester (11)  
 Chiger, Alexander S. (7)  
 Childers, Robert J. (20)  
 Chilton, Forrest S. (16)  
 Chimacoff, Hyman (7)  
 Chmelnik, Abraham G. (7)  
 Chodosh, Maurice A. (20)  
 Chrisman, Irving (16)  
 Christensen, Alexander H. (10)  
 Christian, Albion C. (7)  
 Christian, Henry A. (9)  
 Christoph, Francis T. (7)  
 Church, Franklin H. (17)  
 Ciampa, Ralph P. E. (13)  
 Ciccone, Anthony C. (16)  
 Cieri, Daniel S. (9)  
 Ciliberti, Frank J., Jr. (4)  
 Clarie, D'Arcy C. (2)  
 Clark, Alice L. (11)  
 Clark, Charles C. (9)  
 Clark, Charles E. (11)  
 Clark, Ernest W. (4)  
 Clark, Frank G. (10)  
 Clark, J. Henry (7)  
 Clark, John C. (13)  
 Clark, Orol H. (16)  
 Clark, S. Worth (1)  
 Clarke, Edward W. (2)  
 Clarke, Francis M. (12)  
 Clarken, Joseph A. (7)  
 Claus, C. Hermann (7)  
 Clay, Thomas A. (16)  
 Cleary, Joseph P. (1)  
 Clement, Baxter L. (7)  
 Close, Byron H. (16)  
 Cloud, Albert W. (2)  
 Cochrane, Cleland D. (2)  
 Coe, Richard (7)  
 Coffey, Michael J. (7)  
 Coffin, Henry F. (7)  
 Cogan, Henry (16)  
 Coghlan, Jasper (7)  
 Cohan, Charles C. (11)  
 Cohen, Herman (9)  
 Cohen, Herman (11)  
 Cohen, Herman N. (9)  
 Cohen, I. Elvin (7)  
 Cohen, Julian (16)  
 Cohen, Louis (16)  
 Cohen, M. Marvin (16)  
 Cohen, Maurice (7)  
 Cohen, Maurice B. (5)  
 Cohen, Max (7)  
 Cohen, Meyer J. (7)  
 Cohen, Nathan B. (12)  
 Cohen, Oscar H. (14)  
 Cohen, Paul (4)  
 Cohen, Samuel (9)  
 Cohen, Samuel A. (9)  
 Cohen, Sidney A. (7)  
 Cohen, Sidney L. (7)  
 Cohen, Sidney P. (7)  
 Cohen, William (11)  
 Cohn, Hermann (7)  
 Cohn, Isidor (16)  
 Cohn, Royal M. (7)  
 Colavita, James J. (11)  
 Colby, Maxwell X. (13)  
 Cole, L. Frank (16)  
 Cole, Walter H., Jr. (20)  
 Coleman, Austin H. (10)  
 Coleman, Joseph G. (19)  
 Coleman, Russell M. (7)  
 Collier, Martin H. (4)  
 Collins, Henry J. (11)  
 Collins, Laurence M. (14)  
 Collins, Louis K. (8)  
 Colmer, M. Jonas (7)  
 Colsh, LeRoy L. (7)  
 Colton, Ethan T., Jr. (7)  
 Comando, Harry N. (7)  
 Comeau, George W. (14)  
 Comfort, John B. (11)  
 Communi, Frank F. (11)  
 Comunale, Anthony R. (20)  
 Conaway, Walt P. (1)  
 Conlon, Philip J. (7)  
 Connamacher, Harold S. (7)  
 Connell, Emmet J. (9)  
 Connell, John N. (9)  
 Connelly, John A. (11)  
 Connolly, John J. (7)  
 Connolly, Joseph P. (16)  
 Connolly, Richard N. (7)  
 Connolly, T. Vincent (16)  
 Connolly, Thomas W. (9)  
 Connor, Clarence A. (2)  
 Conroy, John S. (3)  
 Conserva, Peter V. (16)  
 Conti, Horace (17)  
 Conti, Michael (9)  
 Conty, Anthony J. (9)  
 Conway, James V. (20)  
 Cook, Hugh F. (7)  
 Cooke, H. Hamilton (2)  
 Cooke, William H. (7)  
 Cooley, Justus H., II (18)  
 Cooper, Howard M. (2)  
 Cooper, Irving J. (12)  
 Cooper, J. Howard (18)  
 Cooper, Jules (5)  
 Cooper, Robert A. (4)  
 Cooperman, William (7)  
 Copleman, Benjamin (12)  
 Copleman, Hyman B. (12)  
 Coplin, George J. (20)  
 Coppoletta, Joseph M. (2)  
 Corbusier, Harold D. (20)  
 Corio, George A. (11)  
 Corn, David (2)  
 Cornish, Charles H. (7)  
 Cornwell, Alfred (6)  
 Corrigan, Patrick H. (11)  
 Corson, Allen (5)  
 Corson, Filbert R. (1)  
 Corson, Kenneth E. (6)  
 Cortese, Alvin E. (16)  
 Cosgrove, Robert A. (9)  
 Cosgrove, Samuel A. (9)  
 Costa, Philip L. (13)  
 Costabile, Vincent (2)  
 Costello, William F. (14)  
 Cotton, Henry A., Jr. (11)  
 Cotton, Norman T. (16)  
 Cottone, Rosario J. (11)  
 Cottrell, Judson G. (12)  
 Coughlan, Ella A. (7)  
 Coughlin, Frank J. (7)  
 Coughlin, John P. (9)  
 Coughlin, Joseph J. (2)  
 Coultas, Aldo B. (14)  
 Coward, Edwin H. (1)  
 Cowlbeck, Harry D. (11)  
 Cox, Harold C. (11)  
 Cox, John C. (7)  
 Cox, J. Robert (17)  
 Cox, William T. R. (20)  
 Cox, William W. (7)  
 Coxson, Harold P. (4)  
 Crabtree, Loren H. (20)  
 Cracco, Frederick A. (9)  
 Craig, Henry A. (18)  
 Crain, William E. (8)  
 Crandall, John K. (2)  
 Crandell, Archie (14)  
 Crane, Bernard (1)  
 Crane, Charles G. (7)  
 Crane, Norman T. (20)  
 Crankshaw, Orrin F. (20)  
 Craster, Charles V. (7)  
 Crawford, Georgina U. (7)  
 Crawford, John W. (18)  
 Crecca, Anthony D. (7)  
 Crecca, William D. (7)  
 Cregar, John S. (7)  
 Cremens, John F. (16)  
 Crescente, Fred J. (16)  
 Crisonino, Philip D. (9)  
 Crist, Walter A. (4)  
 Cronin, Francis J. (20)  
 Cropsey, Charles D. (2)  
 Crossfield, Henry C. (7)  
 Crounse, David R. (16)  
 Crowe, Aldrich C. (5)  
 Crowley, Leo F. (9)  
 Cryder, Millard C. (5)  
 Crystell, Edward H. (7)  
 Csema, Emery J. (12)  
 Ctibor, Vladimir F. (10)  
 Cufari, Carmine J. (9)  
 Culver, S. Herbert (9)  
 Cummins, George W. (21)  
 Cunningham, Charles, Jr. (6)  
 Cunningham, Joel B. (4)  
 Cupaiuoli, Richard A. (9)  
 Currie, Norman W. (20)  
 Curry, Marcus A. (14)  
 Curtis, A. Maurice (16)  
 Curtis, Donald A. (2)  
 Curtis, Elbert A. (7)  
 Curtis, Howard C. (3)

## ASSOCIATE MEMBERS

- Cantelmo, Alphonse L. (7)  
 Charnock, Maurice P. (11)  
 Chudzik, Edward W. (16)  
 Ciccone, Edwin (7)  
 Citta, J. Philip (15)  
 Ciuccarelli, Francesco (11)  
 Cohen, Joseph (11)  
 Cooperman, Eli L. (12)

## D

### ACTIVE MEMBERS

- D'Acerno, Pellegrino A. (9)  
D'Addario, Anthony R. (7)  
D'Agostini, Henry (2)  
D'Agostini, Robert J. (7)  
Dalberg, Walter (20)  
D'Alessandro, Arthur J. (7)  
Dalton, S. Eugene (1)  
Daly, Edmund J. (9)  
D'Amato, Charles R. (2)  
D'Ambola, Philip R. (7)  
D'Amico, Thomas V. (7)  
Dandois, George F. (5)  
Dane, Charles (7)  
Dane, John (7)  
D'Angelo, Joseph C. (7)  
Danielson, John J. (9)  
Danzis, Maximilian (7)  
D'Arcy, Walter E. (11)  
Darden, Walter T. (7)  
Darlington, Emlen P. (3)  
Daron, Simeon (7)  
Davenport, Irwin P. (11)  
Davey, Thomas N. (9)  
Davidson, E. Norwell (20)  
Davidson, Harold S. (1)  
Davidson, Henry A. (7)  
Davidson, Louis L. (7)  
Davidson, Maurice M. (20)  
Davies, George A. (6)  
Davies, George W. (7)  
Davis, A. Hobson (16)  
Davis, Albert B. (4)  
Davis, Byron G. (1)  
Davis, E. Vernon (3)  
Davis, F. Cleveland (20)  
Davis, Harold L. (11)  
Davis, J. Stannard (4)  
Davis, Jacob M. (3)  
Davis, James T. (20)  
Davis, John E., Jr. (11)  
Davis, Louis (7)  
Davis, Stanton H. (20)  
Davis, Thomas C. (7)  
Davis, W. Cole (1)  
Davison, C. Spencer (17)  
Davison, Royden W. (11)  
Davison, Wilbur S. (17)  
Dawson, Harry (16)  
Day, Grafton E. (4)  
Day, Hayward F. (18)  
Day, Samuel T. (6)  
Day, Willis B. (20)  
Dayton, Spencer T. (2)  
Dean, Guy K., Jr. (11)  
DeBell, Peter J. (16)  
DeBiao, Cornelius V. (2)  
DeCesare, Ferdinand J. (20)  
Decker, Charles T. (20)  
Decker, Henry B. (4)  
Decker, John G. (2)  
Deehl, Seymour R. (20)  
DeFronzo, Morando (7)  
DeFuccio, Charles P. (9)  
DeFusco, G. Thomas (9)  
Degenhardt, Ira H. (12)  
DeGerome, James H. (7)  
DeGrace, Francis H. (16)  
DeHart, George K. (7)  
deHellenbranth, Roland T. (1)  
Deibert, Irvin E. (4)  
Deibert, Kirk R. (4)  
Deich, Samuel R. (16)  
Deichman, Charles H. (14)  
Deitz, Joseph R. (11)  
Delario, Anthony J. (16)  
Del Deo, Nicholas V. (7)  
Del Duca, Vincent P. (4)  
Del Guercio, Olindo (7)  
Del Mauro, Alphonse (16)  
Del Negro, Albert E. (7)  
DeMarco, Silverino V. (9)  
Demarest, Gerald B. (20)  
Demarest, J. Willis (2)  
DeMattia, Michael (16)  
Dembinski, T. Henry (11)  
DeMeritt, Charles L. (9)  
DeMichele, Roland V. (7)  
Dempsey, J. Harvey (4)  
Denbo, Elic A. (4)  
Denelsbeck, J. Otis (11)  
Denes, Oscar (7)  
Dengler, Henry P. (20)  
DePalma, Anthony F. (7)  
DePhillips, Benedict R. (7)  
dePons, Sarah C. (13)  
DeRosa, Armand (16)  
DeRosa, John (16)  
DeRosa, Louis (14)  
DeSantis, Orazio J. (6)  
DeSanto, Anthony M. (2)  
Desmet, Victor F. (16)  
Dessauer, Joseph (7)  
DeTroia, Frederick C. (7)  
Deuell, William D. (2)  
Deutel, Oscar R. (7)  
Deutsch, Nathan S. (20)  
DeVincintis, Henry (7)  
DeVita, Anthony J. (13)  
Devlin, Hugh J. (7)  
Dewis, Edwin G. (13)  
Dexter, Harriet E. T. (9)  
DeYoe, Leon E. (16)  
Dezer, Charles N., Jr. (2)  
Diamond, David I. (13)  
Diamond, J. George (20)  
Dias, Joseph L. (7)  
Dickson, John D. (2)  
Dickson, T. Bruce (3)  
Dieffenbach, Richard H. (7)  
Dieker, Howard E. (12)  
Diener, Samuel (7)  
DiFino, Felix J. (7)  
DiGiacomo, Harry E. (7)  
DiGiacomo, William H. (7)  
Dilger, Frederick G. (2)  
Dillingham, Willis I. (9)  
DiMarino, Anthony J. (8)  
Dimun, John T. (11)  
Dinge, Ferdinand C. (7)  
Dingman, Norman M. (16)  
DiNicolantonio, Vincent J. (1)  
Diskan, Samuel M. (1)  
Diverty, Henry B. (8)  
Dochtermann, Warren P. (14)  
Dodd, Edward L. (7)  
Dodd, William E. (15)  
Dodge, James T. (11)  
Dodson, Louis W. (9)  
Doggett, E. Hugh (20)  
Doktor, David (16)  
Dolganos, Moses (9)  
Dolsky, Irving (20)  
Donahue, William J. (7)  
Donchi, Sol M. (7)  
Donnelly, Joseph E. (16)  
Donnelly, Joseph P. (9)  
Donnelly, William A. (1)  
Donohoe, Lucius F. (9)  
Donovan, Joseph (14)  
Doody, William M. (9)  
Doran, Ralph J. (9)  
Doran, William G. (9)  
Doranz, Harold K. (11)  
Dorn, Elliott I. (7)  
Dougherty, Daniel D. (9)  
Douglass, Stephen A. (16)  
Douglass, William C. (18)  
Dow, Robert F. (16)  
Dowd, Ambrose F. (7)  
Downing, Perley E. (12)  
Downs, Roscius I. (3)  
Doyle, John J. (9)  
Draesel, Charles (9)  
Dragonetti, Elvige N. (7)  
Drake, Daniel E. (16)  
Drake, Leo B. (19)  
Drake, Paul F. (21)  
Dranow, Paul (7)  
Drapkin, Berta (7)  
Dresel, Irmgard (21)  
Dreskin, Jacob L. (7)  
Drezner, Henry L. (11)  
Driscoll, Charles D. (4)  
Driscoll, Raymond S. (9)  
Drossner, Jacob L. (4)  
DuBois, Morris G. (7)  
duBusc, L. C. Victor (20)  
Duckett, Warren J. (9)  
Dukes, Howard R. (9)  
Dulin, Everett V. (7)  
Duncan, Owsley B. (16)  
Dunn, H. Irving (20)  
Dunn, John S. (17)  
Dunn, Theodore B. (7)  
Dunning, Walter L. (16)  
Durchlag, E. Nelson (7)  
Durham, Robert B. (1)  
Durham, Royal E. (1)  
Durrach, Fred F. (20)  
Duschock, Edward F. (12)  
Duvall, Albert I. (13)  
Dwyer, Henry E. (16)  
Dwyer, William A. (16)  
Dyer, Edward H. (1)

### ASSOCIATE MEMBERS

- Dailey, Edward S. (7)  
Dante, Pasquale (7)  
DeLia, Emilio (7)  
Duffy, Edward P. (7)



## E

## ACTIVE MEMBERS

- Eagleton, Wells P. (7)  
 Eames, William N. (11)  
 Earp, Ruth (14)  
 Eason, Samuel W. (20)  
 East, Isaac C. (12)  
 Ebenfeld, Samuel W. (7)  
 Ebner, Paul G. (4)  
 Echikson, Joseph I. (7)  
 Eckert, Walter L. (1)  
 Eckhardt, Ralph A. (14)  
 Eddy, Lester R. (19)  
 Edelberg, Sidney S. (18)  
 Edelen, James J. (7)  
 Edelson, Samuel (13)  
 Edgar, Joseph A. (9)  
 Edgar, Malcolm S. (20)  
 Edgerly, Sherburn E. (2)  
 Edlkraut, Edward C. (16)  
 Edwards, J. Bennett (2)  
 Edwards, Lena F. (9)  
 Ehrenfeld, Edward (16)  
 Ehrenfeld, Irving (16)  
 Ehrlich, Edward (7)  
 Ehrlich, Max (20)  
 Ehrlich, William E. (7)  
 Eichler, Bernard B. (7)  
 Elgen, Louis A. (7)  
 Ein, William B. (7)  
 Einhorn, Samuel E. (7)  
 Eismann, Jerome S. (17)  
 Eisenberg, David S. (7)  
 Ekins, Frank P. (16)  
 Elias, Elmer J. (11)  
 Ellenson, Solomon S. (13)  
 Elliott, Frazier J. (1)  
 Ellis, Alexander (4)  
 Ellis, Arthur J. (7)  
 Ellmers, Basil J. (2)  
 Elsasser, Theodore H. (9)  
 Ely, Lancelot (18)  
 Emerson, Linn (7)  
 Emmer, S. Wolfe (7)  
 Emory, George B., Jr. (14)  
 Engelhart, Ferdinand K. (11)  
 Englander, Charles (7)  
 English, Harrison F., III (11)  
 English, John T. (7)  
 English, Samuel B. (10)  
 Enright, James G. (9)  
 Epler, Don A. (7)  
 Epstein, Harry B. (7)  
 Epstein, Rubie (11)  
 Epstein, William M. (7)  
 Erber, Leonard B. (1)  
 Erdman, George L. (7)  
 Erler, Eugene W. (7)  
 Ernest, Richard B. (11)  
 Ervin, Millard B. (7)  
 Esposito, Anthony L. (16)  
 Essertier, Edward P. (2)  
 Esty, Geoffrey W. (20)  
 Etheridge, Charles H. (7)  
 Eulner, Elmer H. (12)  
 Evans, Charles H. (7)  
 Evans, David P. (7)  
 Evans, Edgar E. (17)  
 Evans, Edgar J. (14)  
 Evans, J. Lawrence (9)  
 Evans, J. Lawrence, Jr. (2)  
 Ewens, Arthur E. (1)  
 Ewing, Harvey M. (7)  
 Ewing, Leslie H. (4)  
 Eynon, Harold K. (4)  
 Eynon, James R. (4)

## F

## ACTIVE MEMBERS

- Faber, Edward (9)  
 Fabian, Paul L. (11)  
 Facciolo, Frank (9)  
 Fadden, Francis J., Jr. (2)  
 Fader, Ferdinand (7)  
 Fagan, James L. (12)  
 Fager, Rudolph O. (7)  
 Fagin, Joseph (14)  
 Fahrenbruch, Frederick D. (3)  
 Failing, Brayton E. (7)  
 Failmezger, Theodore R. (14)  
 Faison, John B. (9)  
 Falcone, Nicholas A. (18)  
 Falkinburg, LeRoy W. (15)  
 Falvello, Nicholas A. (14)  
 Fanburg, Sol J. (7)  
 Fanelli, Antonio (12)  
 Farden, Joseph L. (7)  
 Farkas, Gustav (16)  
 Farmer, Vincent (2)  
 Farmer, Walter D. (11)  
 Farr, Irving L. (7)  
 Farr, John C. (9)  
 Farr, Walter J. (2)  
 Farrell, Edgar A. (4)  
 Fasano, Giovanni (7)  
 Fattel, Henry C. (9)  
 Faughnan, Rose C. (7)  
 Faulkingham, Ralph J. (12)  
 Fauquier, Leonard B. (9)  
 Faux, Frederick J. (8)  
 Fava, Philip V. (7)  
 Fazio, Vincent J. (12)  
 Featherston, Daniel F. (13)  
 Fechner, Fred J. (2)  
 Federer, John J. (9)  
 Feher, Ladislav A. M. (12)  
 Fein, Bernard (7)  
 Feinberg, Harry (9)  
 Feinberg, Harry D. (13)  
 Feinsod, Samuel N. (7)  
 Feinstein, Louis (1)  
 Feldman, Frank H. (7)  
 Feldman, Joel (13)  
 Feleppa, Edward E. (20)  
 Felitti, Vincent J. (9)  
 Fell, Alton S. (11)  
 Feller, William (9)  
 Feman, J. George (13)  
 Fendrick, Edward (7)  
 Fenichel, Benjamin (7)  
 Fenimore, Edward D. (9)  
 Fenster, Morton N. (16)  
 Fenton, Tennant E. (13)  
 Ferguson, William E. (7)  
 Fern, Samuel S. (7)  
 Ferrari, Andrew F. (2)  
 Ferrary, Paul B. (16)  
 Ferriss, Ruth B. (14)  
 Fessler, A. James (11)  
 Fessman, John W. (4)  
 Feuer, Joseph A. (7)  
 Fewsmith, Joseph L. (7)  
 Fialk, Harry (9)  
 Ficke, Sylvia A. (9)  
 Fiedler, Michael J. (20)  
 Field, Frank L. (18)  
 Fiering, Abraham M. (16)  
 Fietti, Vincent G. (2)  
 Fifer, William T. (9)  
 Fine, Hyman P. (12)  
 Fine, Irvin J. (12)  
 Fine, M. James (7)  
 Fine, Sydney G. (11)  
 Fineberg, Bernard J. (9)  
 Fineberg, Jacob C. (9)  
 Finegan, Paul J. (11)  
 Finger, Frederick A. (9)  
 Fink, Irving E. (7)  
 Fink, Stanley J. (20)  
 Finke, Charles H. (9)  
 Finke, George W. (2)  
 Finke, John H. D. (2)  
 Finkel, Joshua (7)  
 Finkelstein, Abe S. (7)  
 Finkelstein, Herman (7)  
 Finkle, Lester J. (11)  
 Finkler, Rita S. (7)  
 Finn, Frederick A. (9)  
 Finn, Henry R. W. (9)  
 Finnerty, Urban R. (7)  
 Fiorello, Joseph R. (11)  
 Fischbein, Martin M. (7)  
 Fischer, David D. (7)  
 Fischer, Edward J. (7)  
 Fischman, Harold H. (7)  
 Fish, Clyde M. (1)  
 Fishbein, Elliot (16)  
 Fisher, James A. (13)  
 Fisher, Samuel (16)  
 Fishkoff, Alexander H. (12)  
 Fisler, Charles F. (8)  
 Fitch, Thomas S. P. (20)  
 Fithian, George W. (12)  
 Fitzhugh, William F. (2)  
 Fitzpatrick, Edward F. (7)  
 Fitzpatrick, Leo J. (2)  
 Flanagan, John J. (7)  
 Flax, Charles H. (7)  
 Fleischmann, Viola G. (7)  
 Fleming, Charles L. (17)

Fleming, Joseph A. (7)  
Flichtenfeld, Morris (9)  
Flicker, David J. (9)  
Fliegel, Hilda C. (9)  
Fliegel, William M. (2)  
Flint, Edgar T. (18)  
Flitcroft, William (16)  
Flower, Morrie A. (7)  
Fluck, David A. (11)  
Fluck, Paul H. (10)  
Flynn, Edward A. (7)  
Flynn, Thomas H. (18)  
Foley, James F. (7)  
Fooder, Horace M. (8)  
Forbes, John S., Jr. (14)  
Ford, Theodore R. (7)  
Forer, Robert (11)  
Forney, Norman N. (12)  
Forney, Norman N., Jr. (12)  
Forsyth, Kenneth C. (7)  
Fort, J. Irving (7)  
Fort, William B. (20)  
Forte, Daniel L. (7)  
Forte, F. Chester (2)  
Forte, Frank S. (7)  
Fortuin, Floyd (16)

Fortunato, Samuel J. (7)  
Fost, William H. (7)  
Foster, Frank L. (20)  
Foster, Herbert W. (7)  
Fourcher, Kenneth R. (20)  
Fowler, Royale H. (7)  
Fox, William W. (1)  
Frame, Dorothy L. (7)  
Frank, Morris (9)  
Frank, Myrtle (1)  
Frank, Nathan (9)  
Frank, Perry (1)  
Frank, Reuben (3)  
Franklin, Frank A. (7)  
Franklin, I. Harold (9)  
Franklin, Joseph E. (20)  
Franklin, Lewis J. (20)  
Franzoni, Andrew E. (11)  
Fratantuno, Michael J. (7)  
Frazee, William H., Jr. (15)  
Freedman, Harold H. (13)  
Freedman, Jacob S. (16)  
Freeland, Frank (2)  
Freeman, George C. (7)  
Freeman, Joseph (9)  
Freeman, Ray M. (20)

Freeman, Richard D. (7)  
Freinkel, Jacob (7)  
Freyberger, George A. (9)  
Friedburg, George H. (20)  
Friedenthal, Bernard (12)  
Friedland, Arnold J. (5)  
Friedman, Abraham I. (2)  
Friedman, Harry (7)  
Friedman, Hyman (7)  
Friedman, Max (11)  
Friedman, Meyer H. (11)  
Friedman, Milton (7)  
Friedmann, Leonard L. (11)  
Friedrich, Adam H. (7)  
Frieman, Hyman (9)  
Fritts, Lewis C. (18)  
Fritz, John F., Jr. (10)  
Froelich, Joseph C. (7)  
Frohwein, Ida H. (20)  
Frost, Inglis F. (14)  
Frutig, Harold C. (9)  
Fuchs, Jacob N. (11)  
Fuhrmann, Barclay S. (10)  
Furman, Benj. A. (7)  
Furman, Sol T. (9)  
Furst, Nathan J. (7)

#### ASSOCIATE MEMBERS

Feliciano, Vincent (16)

Fenwick, John R. (16)  
Forman, Douglas N. (11)

Fritsch, Alfred (7)

## G

#### ACTIVE MEMBERS

Gadek, Stanley A. (12)  
Gadomski, Casimir F. (20)  
Gaidner, Thomas M. (8)  
Galgoczy, Julius (18)  
Galioto, Frank M. (7)  
Gallardo, Augustin (16)  
Galloway, George E. (20)  
Gallo, James S. (16)  
Gamba, Joseph (7)  
Gambill, Perry J. (14)  
Gamon, Robert S. (4)  
Ganley, Arthur J. (7)  
Gannon, Joseph M. (20)  
Ganot, Frank I. (7)  
Gardam, Joseph W. (7)  
Gardner, Kenneth E. (7)  
Garfinkel, Abraham (10)  
Garrison, W. Sherman (6)  
Garwood, Norman W. (11)  
Gatti, Joseph D. (2)  
Gauch, William (7)  
Gaumer, George W. (15)  
Gauzza, Valentine P. (12)  
Geary, Daniel J. (14)  
Geary, Paul (20)  
Geary, Russell D. (3)  
Geiger, Harold C. (16)  
Geissler, Elmer E. (4)  
Gelb, Jerome (7)  
Gelber, Isaac (20)  
Geller, Samuel (7)  
Gelman, Sidney (16)  
Gennell, Ernest (7)  
George, Melbourne E. W. (7)  
Gerard, Patrick D. (7)

Gerendasy, Julius (20)  
Germain, Raymond J. (10)  
German, George B. (4)  
Gerne, Timothy (9)  
Gerner, Harry E. (9)  
Gershenfeld, David B. (7)  
Gershman, Joseph G. (2)  
Gessner, Gerard R. (12)  
Gesswein, Carl A. (13)  
Ghee, Euclid P. (9)  
Giacalone, Vincent (6)  
Giambra, Sante M. (16)  
Giannetti, Ernest D. (7)  
Giardina, John S. (7)  
Gibb, Alice S. (20)  
Gibb, W. Blake (14)  
Gibbins, A. Leslie (7)  
Gibson, Augustus (7)  
Giffoniello, Arthur A. (7)  
Gifford, William R. (7)  
Giglio, Alphonsus S. V. (20)  
Gilady, Raphael (2)  
Gilbert, Phillip D. (4)  
Gilbertson, Robert L. (14)  
Gilligan, Walter W. (7)  
Gillis, Alfred G. (8)  
Gillson, Hugh V. (16)  
Gilman, Charles M. B. (7)  
Gilmour, John R. (7)  
Gilpin, Fletcher (20)  
Gindhart, John H. (11)  
Ginsberg, George (9)  
Ginsburg, Samuel (16)  
Giordano, William C. (2)  
Gittelman, Morton (20)

Gittelsohn, Isador (2)  
Gitterman, David A. (2)  
Giudice, Vincent W. (2)  
Giuffra, Frank (7)  
Gladstone, Albert L. (2)  
Gladstone, Sidney A. (16)  
Glaser, Emanuel (20)  
Glasgow, Thomas M. (16)  
Glass, Benjamin E. (20)  
Glass, Harry L. (20)  
Glass, Oscar (7)  
Glass, William H. (7)  
Glasser, Benjamin F. (12)  
Glassner, Frank (20)  
Glasston, Hyman M. (20)  
Glazebrook, Francis H. (14)  
Glazer, Edward (13)  
Glazier, Jesse T. (7)  
Gleeson, William J. (9)  
Glover, Lawrence L. (4)  
Gluckman, Saul K. (7)  
Gnassi, Angelo M. (9)  
Gochman, Harry M. (16)  
Godfrey, Alan O. (7)  
Goeller, Jacob D. (7)  
Goff, Frank J. (13)  
Goffman, Emanuel (7)  
Goldberg, Benjamin M. (11)  
Goldberg, David (2)  
Goldberg, Harold H. (7)  
Goldberg, Harry C. (12)  
Goldberg, Isidore (12)  
Goldberg, Louis E. (7)  
Goldberg, Samuel A. (7)  
Goldberg, Samuel M. (7)

Golden, Clement H. (7)  
 Golden, William M. (20)  
 Goldenberg, Raphael R. (16)  
 Goldfarb, Abraham (2)  
 Goldfield, Harold H. (20)  
 Golding, Harry N. (16)  
 Goldmacher, Herman B. (20)  
 Goldman, Jerome (7)  
 Goldman, Leo L. (11)  
 Goldman, Lester M. (7)  
 Goldman, Samuel (4)  
 Goldman, Solomon (12)  
 Goldmann, Joseph (7)  
 Goldowsky, Ira (9)  
 Goldsmith, Alfred S. (9)  
 Goldstein, Abraham (15)  
 Goldstein, Henry Z. (7)  
 Goldstein, Herman H. (20)  
 Goldstein, Hyman I. (4)  
 Goldstein, Joseph D. (9)  
 Goldstein, Samuel (1)  
 Goldstein, Samuel M. (7)  
 Goldstein, William H. (7)  
 Goldstone, Karl H. (9)  
 Gonczy, Edward J. (20)  
 Good, Richard (9)  
 Goodfellow, Gordon P. (7)  
 Goodrich, Stewart L. (9)  
 Gordon, A. Julius (7)  
 Gordon, Abel (16)  
 Gordon, Benjamin L. (1)  
 Gordon, Charles D. (14)  
 Gordon, Frank S. (21)  
 Gordon, Isaac L. (9)  
 Gordon, J. Berkeley (13)  
 Gordon, Milton H. (4)  
 Gordon, Samuel (16)  
 Gorenberg, Harold (9)  
 Gormley, Cyrus M. (16)  
 Gorson, Samuel F. (1)  
 Gottlieb, Morris (1)

Gould, John H. (16)  
 Gould, Werner (2)  
 Graddick, Lester W. (14)  
 Grady, William F. (7)  
 Graeter, F. Albert (16)  
 Graham, Archibald F. (16)  
 Graham, Ernest E. (11)  
 Graham, Richard B. (15)  
 Graham, Theodore K. (16)  
 Gramsch, A. Louis (2)  
 Granberry, D. Webb (7)  
 Granelli, Humbert A. (9)  
 Grant, William E. (20)  
 Grant, William F. (7)  
 Grasso, Anthony P. (7)  
 Graves, Charles C. Jr. (13)  
 Gray, Charles M. (6)  
 Gray, John W. (7)  
 Gray, W. Burritt (18)  
 Green, David W. (17)  
 Green, Thomas J. (15)  
 Greenberg, George A. (18)  
 Greenberg, Max (20)  
 Greenberg, Nathan H. (7)  
 Greenberg, Philip (9)  
 Greenberg, Samuel (7)  
 Greenberg, Solomon (9)  
 Greene, Albert D. (9)  
 Greene, Edwin C. (6)  
 Greene, Harry (9)  
 Greenfield, Arthur W. (2)  
 Greenfield, Bernard H. (7)  
 Greenfield, Leonard S. (7)  
 Greenfield, William J. (2)  
 Greengrass, Jacob J. (16)  
 Greenwald, Theodore L. (7)  
 Greenwood, William R. (12)  
 Greer, Melvin A. (7)  
 Gregorius, Ralph F. (7)  
 Gregory, Marie F. (14)  
 Gregory, Mildred G. (7)

Greifinger, Marcus H. (7)  
 Greifinger, William (7)  
 Grenhart, George W. (4)  
 Gricco, Anthony L. (6)  
 Grieco, Emil H. (9)  
 Grier, Robert M. (1)  
 Griesemer, Z. Lawrence (20)  
 Grieve, James (12)  
 Griffey, William C. (4)  
 Griffin, Guy B. (7)  
 Griffith, Roy (7)  
 Griscom, I. Norwood (14)  
 Griscom, Lee E. (4)  
 Griswold, Merton L., Jr. (20)  
 Groeschel, August H. (19)  
 Groff, Parker A. (2)  
 Grosfeld, William (16)  
 Gross, Isidore (7)  
 Gross, Max (1)  
 Grossblatt, Philip (7)  
 Grossman, Morris (9)  
 Grossman, Rubin (9)  
 Grubin, Harold (7)  
 Grueninger, Edward F. (2)  
 Gruhler, Jean A. (1)  
 Guertin, Diomede (18)  
 Guglielmelli, Angelo D. (11)  
 Guidi, Guido M. (20)  
 Guidotti, Frank P. (11)  
 Guillion, Wm. H. (13)  
 Guion, Edward (1)  
 Gulick, James B. (7)  
 Gullord, Edward G. (7)  
 Gurley, Katharine A. (9)  
 Gurnee, Quinby D. (16)  
 Gurshman, Sol. (12)  
 Guthrie, Wilson G. (7)  
 Gutmann, Erwin K. (9)  
 Gutowski, Joseph M. (12)  
 Gutowski, Walter T. (7)

#### ASSOCIATE MEMBERS

Gehl, Sidney H. (7)  
 Gereben, Arpad G. (12)  
 Giardina, Vincent J. (7)  
 Gobel, Stanley J. (12)

Goldman, Sol B. (16)  
 Goodman, Kenneth (7)  
 Gorog, Nicholas M. (12)  
 Gorten, Manfred L. (7)

Greenberg, Jacob L. (7)  
 Greenberg, Mortimer (7)  
 Gruber, William L. (7)

## H

#### ACTIVE MEMBERS

Hackett, Edward J. (20)  
 Hadley, C. Frazer (4)  
 Hadley, C. Frazer, Jr. (4)  
 Hadley, Elinor E. (7)  
 Hafetz, M. Morris (11)  
 Hagen, Orville R. (16)  
 Hagen, Walter H. (7)  
 Haggerty, D. Leo (11)  
 Hagman, Frank E. (7)  
 Hahn, Katherine B. (7)  
 Hahn, William H. (7)  
 Haight, Harry W. (12)  
 Haines, Edgar J. (3)  
 Haines, Emerson S. (13)  
 Haines, Evelyn M. (11)  
 Haines, F. B. Lane (5)  
 Haines, Mabel C. S. (4)  
 Haines, Willits P. (5)

Halbstein, Bernard M. (13)  
 Haldeman, Robert E. (3)  
 Haley, Paul W. (7)  
 Hall, Perry O. (9)  
 Hall, Wayne W. (16)  
 Hall, Winthrop H. (20)  
 Hallett, Frederick S. (2)  
 Halligan, Earl J. (9)  
 Halligan, Harold J. (9)  
 Hallinger, Earl S. (4)  
 Hallock, Wilton J. (20)  
 Halnan, John J., Jr. (16)  
 Halperin, David (9)  
 Halpern, Herman (2)  
 Halpern, Jesse O. (2)  
 Halpern, Melvin M. (7)  
 Halpern, Samuel (1)  
 Halpern, Sophia L. (9)

Halpern, William (7)  
 Halprin, Harry (7)  
 Halsey, Levi W. (7)  
 Hamblin, Donald O. (18)  
 Hambright, Arthur M. (16)  
 Hamilton, Lloyd A. (10)  
 Hamilton, Robert G. (7)  
 Hamley, John J. (7)  
 Hammell, Frank M. (11)  
 Hampton, George R. (14)  
 Hanan, James T. (7)  
 Hancock, Michael Q. (13)  
 Handler, Harry (9)  
 Haney, John J. (11)  
 Hansen, Harry (20)  
 Hanson, Alfred S. (4)  
 Hanson, Carl G. (20)  
 Hantman, Harold (7)



- Harden, Albert S. (7)  
Harden, Albert S., Jr. (7)  
Hardy, John W. (13)  
Harley, Halvor L. (1)  
Harman, James R. (11)  
Harman, William J. (11)  
Harreys, Charles W. (16)  
Harrington, J. Henry (14)  
Harris, Morris (7)  
Harris, William G. (8)  
Harris, William O. (1)  
Harrop, George A. (11)  
Harryman, William K. (2)  
Harter, Louis F. (9)  
Hartman, Luther M. (3)  
Hartman, Winfield L., Jr. (7)  
Hartwell, H. Ameroy (9)  
Harvey, John W. (9)  
Harvey, Robert K. (7)  
Harvey, Thomas W., Jr. (7)  
Harz, William V. (9)  
Haschec, Walter (7)  
Haseltine, Sherwin L. (20)  
Haskin, Aaron H. (7)  
Hasking, Arthur P. (9)  
Hatch, Harold S. (14)  
Hatcher, George A. (7)  
Hatem, Elias J. (16)  
Hauber, Eugene A. (12)  
Hauck, Lydia R. B. (7)  
Hauck, William H. (7)  
Hauptman, Harry (9)  
Haury, Victor G. (4)  
Hausman, Samuel W. (13)  
Haven, Samuel C. (14)  
Hawes, Vernon L. (2)  
Hawkes, E. Zeh (7)  
Hawkes, Stuart Z. (7)  
Hayes, Gerald W. (7)  
Hayman, Irving R. (16)  
Haywood, Henry (12)  
Heatley, William (13)  
Heaton, Stuart C. (18)  
Hebble, Howard M. (3)  
Hegeman, Runkle F. (18)  
Heil, Alva A. (10)  
Heineken, Theodore S. (7)  
Hekimian, Jacob H. (9)  
Helff, Joseph R. (2)  
Heller, Abraham R. (7)  
Heller, George (2)  
Heller, Nathan B. (7)  
Heminway, Norman L. (18)  
Hemphill, Everett H. (4)  
Henderson, Kenneth P. (1)  
Henle, Carye-Belle (7)  
Hennig, Paul F. (7)  
Henriksen, J. Bruce (15)  
Henry, Frank C., Jr. (12)  
Henry, George (10)  
Hensle, Otto S. (2)  
Herbener, Eugene G. (15)  
Hermann, John H. (7)  
Hernandez, Manuel (9)  
Herndon, Lewis S. (7)  
Herold, Harvey T. (7)  
Herradora, Juan R. (9)  
Herrington, Lee R. (20)  
Herrman, William G. (13)  
Hersohn, William W. (1)  
Hess, George A. (11)  
Hess, L. Elmore (1)  
Hesseltine, Clair E. (12)  
Hessert, Edmund C. (4)  
Hewson, George F. (7)  
Hexamer, Fred (7)  
Heyman, Arthur (7)  
Heymann, Ernest F. (13)  
Hicks, Alfred M. (7)  
Hiden, Joseph C. (11)  
Higgins, Gerald L. (9)  
Higgins, John T. (9)  
Higgins, Thomas A. (9)  
Hiler, Stuart A. (14)  
Hilker, George F. (12)  
Hill, Clarence T. (20)  
Hill, Dean F. (19)  
Hill, James O. (7)  
Hill, John A. (13)  
Hill, Robert H. (7)  
Hill, William F. (9)  
Hillel, Joseph (9)  
Hilliard, William T. (17)  
Hillmann, Frederick C. (16)  
Hillsman, R. Bryan (2)  
Hindle, F. Lawton (13)  
Hinton, Samuel H. (12)  
Hipple, Percy L. (20)  
Hird, Emerson F. (18)  
Hirsch, John J. (2)  
Hirsch, Solomon (9)  
Hirschberg, Samuel (7)  
Hirschfield, Bernard A. (11)  
Hirst, E. Reed (4)  
Hitzemann, Louis A. (2)  
Hnat, Frederick (20)  
Hobart, Richard T. (7)  
Hochheimer, Arthur (18)  
Hodas, Sidney M. (13)  
Hofer, Clarence J. M. (12)  
Hoffman, Charles A. (20)  
Hoffman, Charles W. (12)  
Hoffman, Florentine M. (12)  
Hoffman, Harry S. (1)  
Hogan, Carlton P. (3)  
Hogan, James J. (15)  
Hogan, Marshall D. (14)  
Holland, Moses H. (9)  
Holland, Reuben J. (20)  
Holler, Henry G. (7)  
Hollingsworth, H. Hale (16)  
Hollinshead, Beulah S. (4)  
Hollinshead, Ralph K. (8)  
Hollywood, James L. (9)  
Holman, Francis W. (13)  
Holmes, George J. (7)  
Holmes, Grace A. (20)  
Holmes, Thomas J. E. (16)  
Holoman, M. Browne (1)  
Holt, Edward Z. (1)  
Holt, Evelyn (20)  
Holt, Herman H. (16)  
Holters, Otto R. (13)  
Holtz, Harry M. (7)  
Holtzman, Michael (20)  
Hoops, Harold J. (9)  
Hooton, Thomas C. (7)  
Horhovitz, George I. (11)  
Horland, Aaron H. (7)  
Horn, Harry (7)  
Horn, Max (7)  
Hornberger, J. Howard (3)  
Hornstine, Harry H. (5)  
Horoschak, Anne (20)  
Horowitz, Herman J. (2)  
Horre, George W. H. (20)  
Horsford, Frederick C. (7)  
Hosp, Paul H. (7)  
Howard, J. Edgar (4)  
Howell, Thomas W. (7)  
Howeth, John L. (9)  
Hubach, Maximilian F., Jr. (7)  
Hubbard, Fayette E. (7)  
Hubbard, Harry H. V. (20)  
Hubbard, Robert Y. (7)  
Huber, William H. (7)  
Huberman, John (7)  
Hubert, Antonio O. (14)  
Hudson, Howard S. (1)  
Hudson, Woodburn J. (1)  
Hughes, Frank R. (5)  
Hughes, Frederic J. (20)  
Hughes, J. Vernon (16)  
Hughes, Joseph F. (8)  
Hughes, Lee W. (7)  
Hughes, Samuel B. (5)  
Hughes, Thomas E. (4)  
Hulett, Albert G. (7)  
Hull, Donald B. (2)  
Humbert, Joseph C., Jr. (21)  
Hummel, Ernest G. (4)  
Hummel, Lee C. (17)  
Hummel, Merwin L. (4)  
Humphrey, Hubert G. (20)  
Humphries, Robert E. (7)  
Hunt, Melvin M. (12)  
Hunt, Thomas F. (20)  
Hunter, Edward R. (3)  
Hunter, Floyd D. (11)  
Hunter, Harold H. (8)  
Hurff, J. Wallace (7)  
Husserl, Siegfried (7)  
Husted, Gerald H. (4)  
Husted, Samuel H. (18)  
Hutchinson, A. Dunbar (11)  
Hutchinson, George F. (11)  
Hutner, Cyril I. (12)  
Hutton, Frederick T. (20)  
Hyman, Charles (1)  
Hymowitz, Ben (7)

# ASSOCIATE MEMBERS

- Hirsch, Theodore (7)  
Holderith, Albert E. (7)

## I

## ACTIVE MEMBERS

Ianacone, John A. (16)  
Ill, Carl H. (7)  
Ill, Edmund W. (7)  
Ill, Edward J. (7)  
Ill, Herbert M. (7)  
Imbleau, Joseph E. L. (20)  
Imhoff, John G. (9)  
Imhoff, Robert E. (3)

Infield, Gerald L. (1)  
Inge, Hutchins F. (7)  
Ingling, Harry W. (13)  
Introcaso, Dominick A. (9)  
Iraggi, James V. (16)  
Ironside, Paul A. (4)  
Irvin, John S. (1)  
Irwin, James R. (7)

Irwin, John H. (2)  
Isaac, Benoit C. (7)  
Ishkhanian, Nouri I. (9)  
Israeloff, Howard H. (7)  
Ivins, William C. (11)  
Ivory, Harry S. (15)  
Izenberg, David (16)

## ASSOCIATE MEMBERS

Idelcowitz, Marie (12)

Irmisch, George W. (11)

## J

## ACTIVE MEMBERS

Jablonski, John J. (12)  
Jack, H. Wesley (4)  
Jacks, Oscar (9)  
Jackson, Albert F. (7)  
Jackson, Charles H. (4)  
Jackson, Dominick P. D. (16)  
Jackson, Elmer C. (7)  
Jackson, George H. (7)  
Jacobitti, Edmund E. (2)  
Jacobs, Alan (20)  
Jacobs, William (7)  
Jacobson, J. Joseph (1)  
Jacobson, Murray B. (12)  
Jaffe, Benjamin (9)  
Jaffe, Herman M. (9)  
Jaffe, Hyman (16)  
Jaffin, Abraham E. (9)  
Jahn, Albert G. (16)  
James, Bart M. (7)  
James, J. Thomas (11)  
James, William L. (7)  
Jamison, William F. (13)  
Jani, Frank F. (16)  
Janifer, Clarence S. (7)  
Janoff, Henry (11)  
Jaques, J. Eugenia (9)

Jarmulowsky, Harry (16)  
Jaso, James V. (7)  
Jaspan, Samuel C. (11)  
Jedel, Meyer (7)  
Jehl, Joseph R. (16)  
Jenkins, Alvah R. (2)  
Jenkins, Arthur M. (10)  
Jenkins, R. Jewett (7)  
Jennings, Robert E. (7)  
Jensen, Grover H. (9)  
Jentz, John H. (9)  
Jessurun, Samuel H. (7)  
Jirouch, Edwin A. (17)  
Joelson, Dora (16)  
Joelson, Morris S. (16)  
Joffe, Philip M. (16)  
Joffe, Sidney H. (16)  
Johnsen, Sigurd W. (16)  
Johnson, Archie W. (9)  
Johnson, George F. (19)  
Johnson, G. Leonard (2)  
Johnson, Harold F. (20)  
Johnson, Herbert F. (4)  
Johnson, John F. (11)  
Johnson, V. Earl (1)  
Johnston, Julian F. (14)  
Johnston, Rufus O. (2)

Johnston, Sidney F. (2)  
Jonas, August (6)  
Jones, Clement M. (9)  
Jones, Edward C. (7)  
Jones, Elwood K. (7)  
Jones, Granville L. (13)  
Jones, Herbert E. (20)  
Jones, J. Morgan (9)  
Jones, John C. (4)  
Jones, Lewis H. (20)  
Jones, Rhys (7)  
Jonitz, Robert (7)  
Jordan, Alexander D. (13)  
Jordan, Joseph C. (13)  
Jordan, Walter L. (2)  
Joseph, Benjamin M. (9)  
Joseph, Morris (16)  
Joy, Ernest H. (15)  
Joyce, Leo H. (16)  
Judd, Wilbur M. (14)  
Judge, John F. (7)  
Judson, G. Vernon, Jr. (4)  
Judy, Kenneth H. (9)  
Jukofsky, Isidore D. (2)  
Just, Francis (7)  
Justin, Arthur W. (9)

## ASSOCIATE MEMBERS

Jackson, Kenneth K. (7)

Johnson, Robert A. (7)

## K

## ACTIVE MEMBERS

Kachdorian, Vartan (11)  
Kalerabek, Erwin J. (7)  
Kahn, Leo (1)  
Kahrs, Grace M. (7)  
Kaighn, Charles B. (1)  
Kain, Thomas M. (4)  
Kainer, Herbert (9)  
Kakascik, Emil J. (2)  
Kalb, Samuel W. (7)  
Kallen, Arnold M. (7)  
Kalter, George E. (7)

Kanengiser, Clifford H. (9)  
Kanses, Edmund S. (13)  
Kaplan, Henry L. (7)  
Kaplan, Herman B. (9)  
Kaplan, S. Bernard (7)  
Kaplan, Samuel D. (20)  
Kapp, Carl G. (20)  
Karshmer, Ernest E. (20)  
Karshmer, Nathan (12)  
Kassow, Philip B. (21)  
Kastler, Franz (2)

Katz, Jacob D. (9)  
Katzin, Eugene M. (7)  
Kauffmann, Louis J. (6)  
Kaufman, Jerome G. (7)  
Kaufman, Michael J. (7)  
Kay, Clarence R. (18)  
Kazmann, Harold A. (13)  
Kearney, Edward P. J. (7)  
Kearney, John F. (7)  
Kearney, John V. (9)  
Keating, Charles A. (16)

Keating, Joseph M. (16)  
Keegan, Thomas D. (9)  
Keeney, Cadwell B. (20)  
Keeney, James C. (9)  
Keil, Sigmund S. (20)  
Keim, William F. (7)  
Keir, Floyd E. (2)  
Keith, Theodore R. (7)  
Keller, Michael L. (16)  
Keller, Paul (7)  
Kelley, Charles B. P. (9)  
Kelly, Bernard S. (9)  
Kelly, Harry R. J. (9)  
Kelly, Leo J. (12)  
Kemeny, Imre (12)  
Kemper, Harry T. (20)  
Kennedy, A. Andrew (16)  
Kennedy, Eugene T. (16)  
Kennedy, John W. (9)  
Kennedy, Paul A. (2)  
Kennedy, William M. (7)  
Kenney, John A. (7)  
Keppler, Charles, Jr. (16)  
Kerdasha, George S. (9)  
Kerdasha, Richard F. (4)  
Kern, E. Clarence (7)  
Kerns, Francis J. (7)  
Kessell, John S. (7)  
Kessler, Edward I. (14)  
Kessler, Henry B. (7)  
Kessler, Henry H. (7)  
Keyser, David (4)  
Kibbe, Milton H. (20)  
Kiely, Eugene M. (9)  
Kiessling, Charles E. (7)  
Kilduffe, Robert A. (1)  
Kiley, John E. (7)  
Kim, Gay B. (16)  
Kimmel, Charles (7)  
Kimmel, M. Leonard (9)  
Kimmel, Seymour S. (21)  
Kinczel, John A. (11)  
King, Alden P. (14)  
King, Chester A. (2)  
Kingslow, George L. (2)  
Kinkead, Hilda (14)  
Kinney, Albert G. (4)  
Kinney, Burton O. (16)  
Kirkby, Cyril S. (7)

Kirkman, Leroy G. (7)  
Kirschner, Martin I. (19)  
Kissinger, Donald J. (2)  
Kleiber, Estelle E. (12)  
Klein, Alexander (12)  
Klein, Andrew J. V. (7)  
Klein, Edward C., Jr. (7)  
Klein, Edward F. (12)  
Klein, Henry L. (20)  
Klein, Julius (9)  
Klein, William (12)  
Kleinberger, Harry H. (7)  
Kleiner, Samuel (16)  
Kleinman, Maurice (7)  
Klempner, Paul (11)  
Klenk, Joseph P. (7)  
Kler, Joseph H. (12)  
Kline, George L. (7)  
Kline, Herman (1)  
Kline, Joseph J. (11)  
Kline, Oram R. (4)  
Klompus, Irving (18)  
Klosk, Emanuel (7)  
Klostermann, Julius A. (2)  
Knapp, Richard E. (2)  
Knapp, Victor (13)  
Knauer, Charles H., Jr. (11)  
Knauer, George (20)  
Knight, Augustus S. (18)  
Knight, William T. (2)  
Knowles, Frederick E. (14)  
Knowles, George M. (2)  
Knowles, James S. (6)  
Knox, Charles A. (2)  
Knox, Harriet L. (2)  
Knox, Howard A. (10)  
Kobes, John J. (7)  
Koeck, George P. (7)  
Koelsch, Frederick J. (12)  
Koenig, Bertram (16)  
Koerber, George (16)  
Kohn, Joseph J. (11)  
Kohn, Leo (7)  
Kohn, Ralph B. (11)  
Kohut, George J. (12)  
Kolb, John M. (9)  
Kolodin, Abraham (7)  
Kondor, Joseph S. (11)  
Konzelman, Henry J. (20)

Kooperman, Barnett (9)  
Kooperstein, Samuel I. (9)  
Koplin, A. Herman (11)  
Koplin, Nathaniel H. (11)  
Koppel, Joseph A. (9)  
Kornfeld, Werner (7)  
Kossmann, Walter J. (14)  
Kosterlitz, Henry H. (7)  
Kovaleski, Walter A. (16)  
Kovarsky, Albert E. (12)  
Kovin, Abraham (16)  
Kraemer, Manfred (7)  
Kraemer, Samuel H. (9)  
Krafchik, Louis L. (12)  
Kraissl, Cornelius J. (2)  
Kraker, David A. (7)  
Kralick, Louise C. (2)  
Kralik, Joseph J. (7)  
Kramer, Douglas W. (20)  
Kramer, Samuel E. (12)  
Krans, DeHart (20)  
Krans, Edward S. (20)  
Kratka, William H. (6)  
Krauss, Fletcher I. (14)  
Krausz, Emery (21)  
Kraut, Arthur M. (9)  
Krechmer, Abraham (1)  
Kresch, Philip (9)  
Kreutz, Paul J. (20)  
Krichbaum, Carroll E. (7)  
Krieger, George (16)  
Krohn, Marc (13)  
Kroll, Adolph, Jr. (16)  
Krone, William F. (7)  
Kruger, Alfred L. (9)  
Kruger, William (7)  
Kuchlewski, Edward J. (20)  
Kuder, Joseph M. (3)  
Kuhl, John P. (16)  
Kuhlmann, Alvin E. (9)  
Kuite, George B. (14)  
Kummel, Max (7)  
Kump, Albert B. (6)  
Kun, Bertram (9)  
Kunz, Harold G. (7)  
Kushner, Alexander (20)  
Kustrup, John F. (11)  
Kutner, Charles (4)  
Kwint, Joseph A. (20)

#### ASSOCIATE MEMBERS

Kaletkowski, Marion F. (16)  
Kaney, Emil M. (7)

Keim, William F., Jr. (7)  
Kelemen, Nicholas M. (7)

Klughaupt, Dorothy K. (16)  
Kuperman, Henry L. (7)

## L

#### ACTIVE MEMBERS

Laaauwe, Harold W. (16)  
Labash, Charles S. (16)  
Labow, Joseph J. (20)  
Ladas, George (20)  
Lafferty, Elton B. (7)  
Laird, George S. (20)  
Lakiszak, Roman T. (9)  
Lance, Elton W. (20)  
Landaw, Louis (16)  
Landes, Edwin W. (19)  
Landesman, William (7)  
Landry, Ernest J. (10)

Landshof, Charles A. (9)  
Lane, Austin W. (7)  
Lane, Edgar W. (10)  
Lane, Thomas F. (9)  
Lange, Louis C. (9)  
Lapin, Louis P. (11)  
Lapin, Samuel B. (11)  
Largay, Arthur O. (9)  
Larkey, Charles J. (9)  
Larkey, Irving G. (7)  
Larrabee, Callie H. (20)  
Larson, Henry M. (14)

Larsson, Evert A. (11)  
Lasley, James M. (14)  
Lathrop, Frederic W. (20)  
Lathrope, George H. (14)  
Latona, Joseph A. (2)  
Laudig, Guy H. (14)  
Laurie, Andrew L. (20)  
Lavine, Barney D. (11)  
Lavine, Sidney B. (11)  
Lawless, Edward T. (7)  
Lawrence, Arthur C. (16)  
Lawrence, Elias D. (16)



- Lawrence, William H. (20)  
 Lawsing, G. Conde (9)  
 Lawton, A. Anderson (18)  
 Lazow, S. Manlius (12)  
 Leach, John E. (16)  
 Leaman, Granville M. (7)  
 Le Bel, Louis J. B. (7)  
 Leber, Otto H. (7)  
 Lee, Benjamin F. (4)  
 Lee, Frederick P. (16)  
 Lee, John J. (7)  
 Lee, Thomas B. (4)  
 LeFavor, Dean H. (3)  
 Leff, William A. (7)  
 Lefkowitz, Jacob H. (9)  
 Legato, Samuel F. (2)  
 Leggett, Lindley H., Jr. (20)  
 Leggett, Thomas H., Jr. (20)  
 Lehmacher, Frank (15)  
 Leibovitz, Altan C. (16)  
 Leighton, Robert L. (13)  
 Leining, Albert (9)  
 Leir, J. Krevin (9)  
 Lemay, Albert T. (16)  
 Lemkin, Samuel (7)  
 Lemmerz, Willard H. (2)  
 Lemmon, Junius M. (21)  
 Leonard, George F. (12)  
 Leonard, Isaac E. (1)  
 Leonard, Isaac E., Jr. (1)  
 Leonard, Lothair L. (13)  
 Leonardis, James V. (7)  
 Lepree, Joseph A. (20)  
 Lerman, Irving (20)  
 Leshin, Harry (11)  
 Lesko, Stephen W. (2)  
 Lettiere, Anthony J. (11)  
 Levendusky, Daniel E. (16)  
 Levin, Jack (13)  
 Levin, Joseph (7)  
 Levin, Louis (11)  
 Levin, Murray (7)  
 Levine, David B. (16)  
 Levine, Edward P. (7)  
 Levine, G. Irving (9)  
 LeVine, Israel (16)  
 Levine, Philip (7)  
 Levine, Sidney C. (16)  
 Levinsohn, Sandor A. (16)  
 Levinson, Louis J. (7)  
 Levinson, Reuben (12)  
 Levinson, Robert M. (7)  
 Levison, William (7)  
 Levitt, Jesse N. (7)  
 Levy, Abram (18)  
 Levy, Anna L. (7)  
 Levy, Herman (16)  
 Levy, Irvin (11)  
 Levy, Jack D. (2)  
 Levy, Julius (7)  
 Lewandowski, Edmund E. (7)  
 Lewis, Albert (20)  
 Lewis, Alice B. (2)  
 Lewis, Collins E. (12)  
 Lewis, G. Rae (7)  
 Lewis, Jacob (13)  
 Lewis, Leon (7)  
 Lewis, Thomas K. (4)  
 Liana, Stephen M. (16)  
 Liccese, Emanuel (7)  
 Licks, Frederick C. (7)  
 Liddell, Raymond N. (18)  
 Lieb, Saul (7)  
 Lieberman, David P. (20)  
 Lieberman, Milton L. (20)  
 Lief, Lawrence H. (12)  
 Light, Arthur B. (11)  
 Lihn, Barney (6)  
 Lilien, Bernard B. (7)  
 Lilien, Milton (7)  
 Lilien, Milton M. (20)  
 Linares, A. Carfi (16)  
 Lincoln, Jennings S. (7)  
 Linden, Mortimer H. (9)  
 Lindroth, Lawrence V. (9)  
 Linke, James J. P. (20)  
 Lintz, Sidney Z. (8)  
 Lipkin, Isadore (17)  
 Lipshutz, Benjamin (9)  
 Lipshutz, Charles (9)  
 Lipsitz, Leopold S. (4)  
 Lipstein, William (7)  
 Lipton, Louis (16)  
 Little, William R. (11)  
 Littwin, Charles (2)  
 Liva, Arcangelo (2)  
 Liva, G. Albin (2)  
 Liva, Paul F. (2)  
 Livengood, Baxter A. (8)  
 Livengood, Horace R. (20)  
 Livingston, Paul (7)  
 Lloyd, Samuel J. (11)  
 Llull, Gabriel J. (20)  
 Lobban, Robert B. (9)  
 Lobsenz, Nathan P. (16)  
 Loder, Joseph S. (7)  
 Loeb, William A. (18)  
 Loeser, Lewis H. (7)  
 Loman, Samuel G. (2)  
 Lomauro, James R. (16)  
 Lombardi, Frank L. (2)  
 London, Jules R. (16)  
 London, William (12)  
 Londrigan, Joseph F. (9)  
 Londrigan, Joseph F., II (9)  
 Long, Miles T. (9)  
 Long, Pauline A. (12)  
 Longnecker, John E., Jr. (19)  
 Longsdorf, Harold E. (3)  
 Loori, William A. (9)  
 Lord, C. Donald (2)  
 Lore, Harry E. (6)  
 Lorenzo, Michael J. (13)  
 Losado, Camella A. (20)  
 Lottridge, Dorothy (7)  
 Loux, Henry A. (19)  
 Love, Elizabeth F. (3)  
 Lovejoy, James L. (18)  
 Lovell, John F. (7)  
 Lovett, Joseph C. (4)  
 Low, Donald B. (16)  
 Lowell, Milton E. (20)  
 Lowenstein, Aaron (7)  
 Lowenstein, Ernest C. (20)  
 Lowenstein, Harry A. (7)  
 Lowrey, James H. (7)  
 Lowy, Otto (7)  
 Luban, Benjamin (7)  
 Lucas, W. Fred (3)  
 Lucent, S. Bell (16)  
 Luczynski, Edward W. (9)  
 Lueddecke, Roland E. (2)  
 Luftburo, Charles B. (20)  
 Luippold, Eugene J. (9)  
 Luippold, Eugene J., Jr. (14)  
 Luksteid, Casimir J. (16)  
 Lummis, Clarence P. (17)  
 Lund, John L. (12)  
 Lundblad, Walter E. (7)  
 Luongo, Federico (7)  
 Lupin, Edward E. (9)  
 Luria, Sanford A. (2)  
 Lurie, Solomon I. (7)  
 Lurie, Wolf (7)  
 Lushear, Frank H. (19)  
 Lussier, Georges H. (13)  
 Lutz, William M. (7)  
 Lyster, James M. (20)  
 Lynch, Albert E. O. (7)  
 Lynch, Donald C. (11)  
 Lynch, Edward T. (20)  
 Lynch, Maurice M. (2)  
 Lynch, Roland J. (9)  
 Lynn, Irving I. (9)  
 Lyon, Archibald (7)  
 Lyon, Charles H. (21)  
 Lyon, Earl C. (6)  
 Lyon, Leslie C. (4)  
 Lyons, James V. (7)  
 Lyons, Romola L. K. (2)

## ASSOCIATE MEMBERS

- Lavine, Samuel C. (12)  
 Lee, Robert E. (7)  
 Lehman, David J., Jr. (7)  
 Lima, John G. (16)  
 Long, John F. (7)  
 Lucey, James J. (12)

## M

## ACTIVE MEMBERS

- Maas, Max A. (7)  
 Mabey, J. Corwin (7)  
 MacAlister, William W. (16)  
 MacAlpine, Kenneth B. (4)  
 Macaluso, Dominic C. (7)  
 MacArt, James H. (7)  
 MacArthur, Clymont (7)  
 Macaulay, Francis A. (2)  
 MacBrayer, Reuben A. (20)  
 Macchia, Benjamin J. (9)  
 MacDermid, Lynden (11)  
 MacDonald, John J. (9)

- MacDonald, Wentworth S. (7)  
MacDowall, John L. (12)  
Mace, Margaret (5)  
MacGregor, Allan W. (16)  
MacGuffie, Robert N. (16)  
MacKellar, James M. (2)  
MacKenzie, Robert A. (13)  
Mackes, Claude B. (17)  
Mackin, John J. (9)  
Mackler, Meyer E. (16)  
MacLaren, Philip J. (2)  
MacLay, Joseph A. (16)  
MacMillan, Wright (7)  
Macpherson, Elwood H. (7)  
Madaras, John S. (9)  
Madden, Leland S. (1)  
Madden, Theophilus W. (4)  
Madden, William L. (9)  
Maddren, Russell F. (2)  
Mader, A. Ivan, Jr. (2)  
Madison, L. Keith (9)  
Maffongelli, Joseph A. (16)  
Magee, Edward S. (4)  
Magee, Harold S. (11)  
Magee, Russell S. (4)  
Maggio, George A. (7)  
Maggio, Ross J. (20)  
Magill, Marcus (1)  
Magnes, Max (16)  
Magolda, Anthony F. (6)  
Magovern, Thomas F. (7)  
Magson, Albert E. (11)  
Mahaffey, J. Lynn (4)  
Maher, John E. (13)  
Mahood, Herbert L. (7)  
Maisel, Irving (7)  
Majeski, Henry J. (11)  
Major, Morton M. (1)  
Makin, John B. (13)  
Malatesta, Charles S. (20)  
Maldeis, Albertos M. K. (4)  
Mamlet, Alfred M. (7)  
Manahan, Daniel V. (13)  
Mancene, Edward M. (2)  
Mancusi-Ungaro, Elviro (7)  
Mancusi-Ungaro, Lodovico (7)  
Mangelsdorff, Arthur F. (18)  
Mangogna, Philip (12)  
Manly, Thomas E. (16)  
Mann, Jacob J. (12)  
Manzione, Frank A. (16)  
Maps, Howard L. (16)  
Maras, Peter E. (9)  
Marcarian, Henry G. (4)  
Marchione, Nicholas E. (6)  
Marcus, Donald (7)  
Marcy, John W. (4)  
Margaretten, Edward I. (12)  
Margolin, Samuel J. (9)  
Margolis, Alfred (7)  
Margulies, Charles (7)  
Marini, Dominick (16)  
Mark, Harry B. (3)  
Mark, Joseph S. (12)  
Markel, Albert G. (16)  
Markley, Luther A. (2)  
Markowitz, Benjamin B. (9)  
Markowitz, Irwin B. (9)  
Markowitz, Louis (16)  
Marks, Edward G. (7)  
Marks, Zelda I. (7)  
Marlett, Neumann C. (21)  
Marone, Carmine R. (20)  
Maroney, James H. (20)  
Marquis, Dean W. (7)  
Marquis, W. James (7)  
Marra, Rocco S. (7)  
Marrocco, William A. (16)  
Marsh, Elias J. (16)  
Marshall, Frank A. (9)  
Marshall, H. Donald (1)  
Martin, Leonard J. (13)  
Martin, Theodore (16)  
Martin, William P. (7)  
Martland, Harrison S. (7)  
Marts, George H. (20)  
Marvel, Peter H. (1)  
Marvin, Dorothy H. (12)  
Marx, Frederick J. (2)  
Mason, Howard B. (13)  
Mason, James H. (1)  
Mason, Virgil A. (7)  
Massengill, Fulton (7)  
Massey, J. Bruce (12)  
Masterson, John F. (7)  
Mastroianni, Frank M. (20)  
Mastromonaco, Joseph D. (9)  
Masucci, Alberico (16)  
Matera, Joseph (9)  
Matheke, George A. (7)  
Matheke, Otto G. (7)  
Matheke, Otto G., Jr. (7)  
Mathesheimer, Jacob L. (9)  
Matheson, Gilchrist E. (7)  
Mathews, Raymond H. (14)  
Mathews, William J. (9)  
Mathis, John H. (1)  
Matthews, Clifford B. (7)  
Matthews, Harry E. (7)  
Matthews, Leonard M. (16)  
Matthews, William (13)  
Matthews, William F. (7)  
Matturri, Dominick A. (9)  
Maturi, Vincenzo E. (9)  
Maurer, K. Virginia (7)  
Maver, William W. (9)  
Maxwell, Carl A. (21)  
May, Ernst A. (7)  
Mayhew, Charles H. (6)  
McAlpine, Paul (20)  
McBride, Andrew F. (16)  
McBride, Andrew F., Jr. (16)  
McCall, Jesse (19)  
McCallion, William H. (20)  
McCamey, Kenneth E. (16)  
McCandliss, William K. (11)  
McCarroll, E. Mae (7)  
McCarron, James A. (9)  
McCarthy, Arthur M. (4)  
McCarthy, Cornelius P. (9)  
McCarthy, George L. (16)  
McCarthy, William P. (11)  
McCauley, Francis J. (7)  
McConaghy, Thomas P. (4)  
McConaughy, Francis (18)  
McCorkle, William E. (10)  
McCormack, Frank C. (2)  
McCormick, James E. (7)  
McCormick, William H., Jr. (12)  
McCreight, David W. (13)  
McCroskery, James H. (7)  
McCue, John B. (16)  
McCullough, John H. (11)  
McDede, Frank F. (16)  
McDermott, Vincent T. (4)  
McDonald, Richard J. (16)  
McDonnel, Gerald E. (3)  
McDonnell, George J. (13)  
McElroy, Ervin (14)  
McFeely, Percy R. (2)  
McGeary, John A. (20)  
McGeehan, Stanley M. (1)  
McGinn, William J. (20)  
McGivern, Charles S. (1)  
McGlade, Thomas H. (4)  
McGovern, John F., Jr. (12)  
McGuigan, Francis A. (11)  
McGuire, John J. (7)  
McGuire, Joseph T. (2)  
McKelvie, Julius C. (13)  
McKiernan, Robert L. (12)  
McKim, William F. (7)  
McKinley, C. Scott (20)  
McKinstry, John W. (12)  
McLane, A. Donald (2)  
McLean, Herbert E. (9)  
McLean, Hugh A. (9)  
McLellan, George A. (7)  
McLoughlin, Frank J. (9)  
McLoughlin, John W. (9)  
McMahon, Bernard C. (14)  
McMurray, George B. (14)  
McMurtrie, William A. (21)  
McNenney, Claudio E. (9)  
McPherson, Malcolm E. (16)  
McTague, Robert S. (13)  
McVay, Edward A. (7)  
McVeigh, Charles J. D. (19)  
Meacham, Eugene A. (12)  
Means, Paul B. (11)  
Mears, William G. (2)  
Mecray, Paul M. (4)  
Mecray, Paul, Jr. (4)  
Medd, John C. (7)  
Meehan, George E. (9)  
Meehan, Martin M. (7)  
Meeker, Irving A. (7)  
Meeker, John L. (20)  
Megibow, Harold J. (2)  
Meier, William U. (16)  
Meineke, William C., Jr. (20)  
Meinhard, Fred (7)  
Meinzer, Martin S. (12)  
Mellen, Stanley H. (7)  
Meloney, Lester F. (16)  
Meltsner, Louis (9)  
Meltzer, Louis (9)  
Mendelsohn, David H. (16)  
Mendenhall, Clinton D. (3)  
Meneve, Alfred D. (16)  
Menge, Carl H. (15)  
Mengel, Willard G. (4)  
Menk, Paul E. (7)  
Merendino, Anthony G. (1)  
Merliss, Eugene (7)  
Merlo, Francis A. (20)  
Merlo, Francis V. (20)  
Merrill, Charles F. (12)  
Merrill, Edwin D. (10)  
Merselis, John G. (7)  
Mersheimer, Christian H. (9)  
Messina, Thomas (7)  
Metsky, Joseph (7)  
Metz, Henry (2)  
Metzer, Emma P. W. (3)  
Metzer, Freeman W. (3)  
Metzger, Karl F. (13)  
Meurlin, Alfred (7)  
MeVey, James C. (1)  
Meyer, Eugene A. (3)  
Meyer, George P. (4)  
Meyer, Howard M. (2)  
Meyer, William (9)  
Meyers, Francis R. (16)  
Meyerson, Noah (9)

Mezzetti, Alfred F. (6)  
 Michela, Luigi S. (16)  
 Michell, George E. (14)  
 Michelson, Henry (16)  
 Mickewich, Stephen A. (9)  
 Mierau, Ernest W. (7)  
 Milano, Cesare (1)  
 Miller, Earle K. (11)  
 Miller, George M. (12)  
 Miller, Gerald H. (11)  
 Miller, H. Garrett (6)  
 Miller, Herbert G. (2)  
 Miller, Herman P. (7)  
 Miller, I. Irwin (7)  
 Miller, Joseph A. (7)  
 Miller, Lewis H. (17)  
 Miller, Lucille F. (7)  
 Miller, Max H. (9)  
 Miller, Nathan (7)  
 Miller, Ralph (7)  
 Miller, Reginald C. (11)  
 Miller, Robert M. (20)  
 Miller, S. Thomas (13)  
 Miller, Samuel R. (11)  
 Miller, William H. (17)  
 Milligan, Robert S. (20)  
 Mills, Charles S. (3)  
 Mills, Clifford (14)  
 Mills, Stephen D. (20)  
 Minard, Edwy L. (7)  
 Minier, Carl L. (7)  
 Miningham, William D. (7)  
 Minnefor, Charles A. (7)  
 Minnella, Thomas J. (20)  
 Minschwaner, George G., Jr. (11)  
 Mishell, Daniel R. (7)  
 Mishler, Jay E. (1)  
 Missionellie, Wm. (16)  
 Mitchell, Augustus J. (7)  
 Mitchell, Charles H. (11)

Mitchell, Charles R. (16)  
 Mitchell, Walter L., Jr. (7)  
 Mitskas, Theodore V. J. (11)  
 Mockett, Walter W. (2)  
 Modrys, Walter F. (2)  
 Moeckel, Clarence W. (7)  
 Moffat, Barclay W. (13)  
 Mohair, John P. (13)  
 Mohrbacher, John J. (7)  
 Molitch, Matthew (1)  
 Monaco, Saverio A. (7)  
 Monaloy, Morris A. (16)  
 Monasson-Friedland, Ida (5)  
 Monfort, Robert N. (9)  
 Monte, Thomas B. (14)  
 Montfort, Robert J. (20)  
 Moon, Alexander C. (5)  
 Moore, Dean C. (7)  
 Moore, Ralph L. (8)  
 Mores, Herbert R. (2)  
 Moress, Edward J. (7)  
 Moretti, John J. (7)  
 Morgan, Browne (7)  
 Morganstein, Louis K. (9)  
 Morici, Theodore (16)  
 Moriconi, Albert F. (11)  
 Morley, Grace C. (9)  
 Morris, Carlyle (12)  
 Morris, Clement (7)  
 Morris, David G. (9)  
 Morris, Karl E. (20)  
 Morris, Nathan (18)  
 Morris, Thomas M. (20)  
 Morris, Watson B. (20)  
 Morrison, Caldwell (7)  
 Morrison, Frederick H. (19)  
 Morrow, Joseph R. (2)  
 Moschkowitz, Hermann (7)  
 Moscoe, Harry A. (16)  
 Mosher, Henry L. (2)

Moss, Mary C. (7)  
 Mott, Joseph E. (16)  
 Motzenbecker, Peter F. (7)  
 Mount, Elmer M. (9)  
 Mount, Walter B. (7)  
 Mountford, William E. (11)  
 Muccia, John J. (9)  
 Mueller, George H. (9)  
 Muldoon, Edward J. (3)  
 Muller, Frederick L. (2)  
 Mulligan, Luke A. (2)  
 Mullin, Eugene F. (7)  
 Mullin, Raymond J. (7)  
 Mullins, Roy L. (10)  
 Munger, Ray T. (20)  
 Munro, Charles A. (3)  
 Munro, Jeannette (11)  
 Murn, Charles J. (16)  
 Murphy, Albert T. (20)  
 Murphy, Charles M. (13)  
 Murphy, Herschel S. (20)  
 Murphy, James A. (11)  
 Murphy, James M. (9)  
 Murphy, Leo J. (9)  
 Murphy, Patrick H. W. (9)  
 Murray, Clifford K. (1)  
 Murray, Harrold A. (7)  
 Murray, Joseph A. (9)  
 Murray, Norman L. (20)  
 Murray, Robert A. (4)  
 Murto, Thomas V. (11)  
 Musetto, Carmelo A. (14)  
 Mustermann, Otto H. (9)  
 Muta, Samuel A. (7)  
 Mutchler, H. Raymond (14)  
 Mutchler, Julia C. (14)  
 Muttart, George W. (9)  
 Mutter, Alfred A. (9)  
 Myatt, Leslie E. (6)  
 Myers, Norman V. (2)

## ASSOCIATE MEMBERS

Maggio, Nicholas A. (7)  
 Mark, George E., Jr. (11)  
 Masciocchi, Thomas A. (7)

McLaughlin, Thomas F. (12)  
 Miller, S. David (12)  
 Modeski, Chester J. (7)

Moore, James A. (7)  
 Moore, John L. (11)  
 Murphy, Thomas W. (7)

## N

## ACTIVE MEMBERS

Nacca, Carl A. (7)  
 Nadel, Charles I. (7)  
 Nadler, Arthur A. (20)  
 Nafash, Shafeek (9)  
 Nafey, Herbert W. (12)  
 Nagler, Benedict (7)  
 Naidorff, Saul A. (20)  
 Nalitt, David I. (9)  
 Nappi, Pasquale E. (7)  
 Nash, Alexander E. (7)  
 Nash, Herman S. (7)  
 Nash, William G. (7)  
 Naulty, Charles W., Jr. (12)  
 Navazio, Attilio (14)  
 Nayfield, Ronald C. (11)  
 Neal, Charles B. (6)  
 Neary, Edward R. (2)  
 Neer, William (16)  
 Neiderhoffer, Sydney L. (13)  
 Nelson, Harry (8)

Nemirow, Martin (16)  
 Nemzek, William P. B. (7)  
 Nesbitt, Elizabeth (16)  
 Netz, Lester W. (2)  
 Neville, Robert J. (2)  
 Nevius, William B. (7)  
 Newbury, Graham C. (20)  
 Newcomb, Marcus W. (3)  
 Newman, Abraham J. (9)  
 Newman, Grace T. (7)  
 Newman, Julius (7)  
 Newmeyer, Joseph (3)  
 Ney, J. Marshall (7)  
 Nichols, Frank I. (2)  
 Nichols, Stanley H. (13)  
 Nicholson, Frank P. (9)  
 Nickman, E. Harrison (1)  
 Nicol, Lorenz C. (2)  
 Nicola, Toufick (7)  
 Nicoll, George L. (14)

Nieman, Solomon Z. (12)  
 Niemtzow, Frank (13)  
 Nitshe, George A., Jr. (6)  
 Nittoli, Rocco M. (20)  
 Nobile, James J. (9)  
 Noll, Louis (7)  
 Nonziato, Frank A. (11)  
 Normand, Alphonse F. (12)  
 North, Harry R. (11)  
 Norton, James F. (9)  
 Norval, William A. (16)  
 Notkin, Meyer (16)  
 Noto, Philip (16)  
 Novello, Joseph A. (20)  
 Nuse, Edward F. (9)  
 Nussbaum, Harvey E. (7)  
 Nussbaum, Joseph (20)  
 Nye, Howard H. (16)  
 Nyiri, William A. (7)  
 Nyvall, Pierre J. (15)

## ASSOCIATE MEMBERS

Neiman, Watson E. (15)

Nelson, Axel R. (12)

Nussbaum, Nathan (16)



# O

## ACTIVE MEMBERS

Oberlander, Gertrude (7)  
Obert, J. Edwin (15)  
Obester, Gabriel E. (20)  
O'Brian, Dennis M. (16)  
O'Brien, Edwin J., Jr. (20)  
O'Brien, Paul (2)  
Ockene, Abraham (9)  
O'Connell, James J. (12)  
O'Connor, Bernard A. (7)  
O'Connor, Dennis F. (7)  
O'Connor, John J. (9)  
O'Connor, Michael J. (7)  
O'Crowley, Clarence R. (7)  
Oderr, Charles (20)  
Offenkrantz, Frederick M. (7)  
Ogden, Andrew E. (11)  
Ogden, Michael A. (16)  
O'Gorman, Michael W. (9)  
O'Grady, Benson J. (9)

O'Grady, Michael J. (7)  
O'Hanlon, George (9)  
Okin, Irving (16)  
Oleynick, Simeon A. (7)  
Olini, Joseph J. (7)  
O'Lin, Louis J. (7)  
Olpp, Archibald E. (9)  
Olpp, John L. (2)  
O'Mara, John A. (13)  
Ondovchak, M. Frederic (4)  
O'Neill, Charles L. (7)  
O'Neill, John H. (9)  
O'Neill, Joseph F. (11)  
Opacity, Ernest A. (7)  
Opdyke, Gordon M. (7)  
Openchowski, Mieczyslaw (7)  
Oppen, Philip (16)  
Oram, Joseph H. (16)  
Oren, Hyman (2)

Orloff, Samuel (7)  
Ornaf, I. Edward (4)  
O'Rourke, James J. (11)  
Orris, Harold J. (7)  
Ortolano, James J. (9)  
Orton, Foster (20)  
Orton, George L. (20)  
Orton, Henry B. (7)  
Osborn, A. Downey (13)  
Osborn, Edward G. (4)  
O'Shea, John J. (9)  
Osher, Morris M. (20)  
Oshrin, Henry (9)  
Osmun, Milton M. (4)  
Osterreicher, Desider (9)  
Ostrowski, Sigismund J. (7)  
O'Sullivan, John R. (9)  
Owen, Logan S. (9)  
Owen, Philip (20)

## ASSOCIATE MEMBER

Oransky, Marvin (7)

# P

## ACTIVE MEMBERS

Pacicco, Michele (9)  
Padden, Aloysius F. (2)  
Paddock, Royce (7)  
Padney, Edward V. (9)  
Pagano, Peter (2)  
Pagliughi, John J. (9)  
Pal, Darbari R. (16)  
Palazzo, William L. (14)  
Pallen, Conde DeS. (2)  
Palma, Nicholas (16)  
Palmer, Francis R. (16)  
Palmer, Henry S. (7)  
Panigrosso, Louis R. (12)  
Panitch, William (7)  
Pannullo, John N. P. (7)  
Pansy, Abraham A. (12)  
Pantaleone, Joseph (11)  
Parell, George C. (7)  
Parent, Sol (7)  
Paris, William (16)  
Park, M. Benjamin (16)  
Parker, Horace N. (11)  
Parker, James W. (13)  
Parker, John E. (7)  
Parry, Allen A. (14)  
Parry, Antoinette R. (14)  
Parry, Oliver K. (13)  
Parsonnet, Aaron E. (7)  
Parsonnet, Eugene V. (7)  
Pascall, Thomas M. (7)  
Patella, Fulvio (16)  
Pattenden, Franklin J. (13)  
Patterson, Isaac N. (8)  
Patti, Frank A. (2)  
Pattysen, Ralph A. (7)  
Paul, George A. (7)  
Paul, H. Carl (7)  
Paulson, Arch M. (20)  
Pavia, John R. (7)

Payne, Guy (7)  
Payne, Guy, Jr. (7)  
Payne, Joseph (2)  
Peacock, Arthur B. (3)  
Pearl, Sydney S. (20)  
Pearlstein, Frank (9)  
Pearson, J. Gerald (9)  
Pearson, Theodore A. (18)  
Pecora, Carmine L. (15)  
Pecora, Samuel (7)  
Pedevill, Joseph R. (2)  
Pedrick, William W. (8)  
Peer, Lyndon A. (7)  
Pegau, Paul M. (8)  
Pellett, Thomas L. (19)  
Pellicane, Anthony J. (12)  
Pelliciani, Donald (7)  
Pendexter, Sidney E. (7)  
Pennington, Alfred W. (7)  
Pennington, John (1)  
Pentecost, Salvador D. (7)  
Perez, John F. (1)  
Perham, Bertram S. (7)  
Perham, Roy G. (2)  
Perkel, Louis L. (9)  
Perlberg, Harry J. (9)  
Pernetti, Anthony M. (16)  
Perrine, Cornelius C. (13)  
Perrone, Anthony J. (7)  
Perrone, Arthur F. (9)  
Perrotta, Anthony J. (13)  
Perry, Frank L. (17)  
Pessel, Johannes F. (11)  
Peters, Edgar A. P. (9)  
Peters, Richard C. (20)  
Peterson, Charles A. (9)  
Peterson, Walter R. (11)  
Petry, William (7)  
Pettit, Harry H. (2)

Pettit, Herschel (5)  
Phelan, Walter F. (20)  
Phelps, James E. (16)  
Phillips, Algernon A. (7)  
Phillips, Claude B. (4)  
Phillips, Walter (2)  
Piasecki, Chester A. (16)  
Pieper, Ernest E. (18)  
Pieper, Howard C. (13)  
Pierce, Henry A. (2)  
Pierson, Carl L. (11)  
Pierson, Joseph R. (11)  
Pietri, Raoul (13)  
Pigott, Albert W. (18)  
Pike, Charles E. (4)  
Pilch, Arthur G. (7)  
Pilkington, Albert (1)  
Piller, Jacob (16)  
Pilloni, Louis (7)  
Piltz, George F. (9)  
Pinckney, Frank H. (14)  
Pindar, Frederick S. (9)  
Pindar, William A. (9)  
Pinerman, Robert B. (11)  
Pington, Eufelia (2)  
Pink, Solomon H. (16)  
Pinkerton, William A. (9)  
Pino, Anthony (6)  
Piskorski, Abdon V. (9)  
Pitkin, George P. (2)  
Pitman, Manson W. H. (18)  
Pittis, Harold E. (20)  
Pittman, Allen R. (11)  
Pizzi, Francis W. (7)  
Pizzi, Mario V. (7)  
Placa, James A. (2)  
Plant, James S. (7)  
Plante, Amos A. (7)  
Platt, Thomas H. (12)

Plavin, Nathan J. (9)  
 Pleasants, Edward N. (13)  
 Plinke, Fritz W. (16)  
 Plume, Clarence A. (14)  
 Podell, A. Alfred (13)  
 Pogoloff, Samuel H. (18)  
 Pois, John (7)  
 Poland, George A. (1)  
 Poleshuck, Rubin (20)  
 Policastro, Nelson C. (2)  
 Polizotti, Joseph L. (16)  
 Polk, Charles C. (20)  
 Pollak, Berthold S. (9)  
 Poller, Frederick K. (7)  
 Pollis, Nicholas L. (7)  
 Pollock, Franklyn J. (7)  
 Polow, Benjamin (7)  
 Polowe, David (16)  
 Pomeranz, Raphael (7)  
 Pons, Carlos A. (13)

Pontery, Herbert B. (9)  
 Potter, Benjamin P. (9)  
 Potter, Ellen C. (11)  
 Potter, Raymond T. (7)  
 Pottinger, William E. (14)  
 Povalski, Alexander W. T. (9)  
 Powis, Ethel M. (11)  
 Poyas, Morton L. (11)  
 Prager, Bert A. (14)  
 Prall, Henry E. (2)  
 Prather, Charles G. (2)  
 Prather, John W. (2)  
 Pratt, Arthur G. (4)  
 Pratt, William H. (4)  
 Preece, John D. (9)  
 Pregnall, James P. (13)  
 Prestifilippo, Silvestro (7)  
 Preston, Perry B. (7)  
 Price, Charles W. (7)

Price, H. Preston (9)  
 Price, Henry S., Jr. (4)  
 Price, Nathaniel G. (7)  
 Prigger, Edward R. (17)  
 Prince, Robert A. (16)  
 Prince, Samuel (9)  
 Principato, Roberto (4)  
 Probst, Everett W. (7)  
 Proctor, Francis E. (11)  
 Proctor, Jesse E. (7)  
 Protzman, Thomas B. (2)  
 Prout, Thomas P. (20)  
 Prout, William B. (2)  
 Provisor, Benjamin (16)  
 Pullen, Guy F. (2)  
 Purcell, Ernest F. (11)  
 Purdy, Charles H. (9)  
 Pyle, Louis A. (9)  
 Pyle, Wallace (9)

#### ASSOCIATE MEMBERS

Pepe, Salvatore A. (11)

Pizzi, Peter J. (2)

Pollock, Theodore (16)

## Q

#### ACTIVE MEMBERS

Quad, Clifford W. (7)  
 Quigley, Frederic J. (9)

Quin, John A. (20)  
 Quinn, John J. (9)

Quinn, Norman J. (1)  
 Quirk, Martin A. (13)

#### ASSOCIATE MEMBER

Quinn, Edward D. (7)

## R

#### ACTIVE MEMBERS

Raab, Michael (16)  
 Rachlin, Harry T. (7)  
 Rader-Hoheb, Katherine A. (2)  
 Rados, Andrew (7)  
 Raffetto, Joseph F. (13)  
 Ragany, Joseph (11)  
 Ragione, Mario D. (7)  
 Rainey, Willard G. (11)  
 Ram, Nathan H. (7)  
 Rampona, Joseph M. (11)  
 Ramsey, F. Muriel (6)  
 Randazzo, Anton P. (16)  
 Ranson, Briscoe B., Jr. (7)  
 Rapalski, Adam J. (7)  
 Rapp, Robert F. (4)  
 Rathgeber, Charles F. (7)  
 Rauschenbach, Paul E. (16)  
 Rauschenbach, Paul E., Jr. (16)  
 Ravits, Everett C. (2)  
 Ravitz, Samuel F. (7)  
 Read, Donald B. (9)  
 Read, Hilton S. (1)  
 Read, Jessie D. (20)  
 Read, William T., Jr. (4)  
 Reading, H. Eugene (16)  
 Reale, Frank P. (18)  
 Reale, Nicholas P. (18)  
 Reeve-Allen, Janc (7)

Reeves, Ernest (16)  
 Reeves, J. Franklin (6)  
 Reich, Abraham L. (7)  
 Reich, Henry (7)  
 Reich, Jerome J. (20)  
 Reich, Mortimer (7)  
 Reich, Samuel B. (2)  
 Reid, Erwin W. (2)  
 Reilly, Christopher J. (7)  
 Reilly, David F. (2)  
 Reilly, John V. (7)  
 Reilly, Thomas F. (16)  
 Reiner, Jacob (20)  
 Reingold, Alexander (9)  
 Reinhardt, Warren I. (7)  
 Reinhold, Herbert E. (2)  
 Reinhorn, Abraham J. (16)  
 Reisinger, Paul B. (11)  
 Reissman, Erwin (7)  
 Reiter, Walter A. (20)  
 Reitman, Norman (12)  
 Reitnauer, John S. (9)  
 Reitter, George S. (7)  
 Relyea, George M. (20)  
 Remer, Daniel F. (3)  
 Remondellia, Raphael E. (7)  
 Renner, Clara C. (18)  
 Renzulli, Francesco (7)

RePass, Paul E. (7)  
 Repici, Anthony J. (1)  
 Resch, Henry U. (7)  
 Restaino, Charles F. (7)  
 Rettig, Isidor L. (7)  
 Revere, Seth D. (7)  
 Reyner, Daniel C. (1)  
 Reynolds, Donald G. (13)  
 Reynolds, George G. (13)  
 Reynolds, Harry C. (16)  
 Rhoads, S. Creadick (8)  
 Rhone, David S. (4)  
 Ribbans, Robert C. (7)  
 Riccobono, Cosmo S. (16)  
 Rice, Franklin W. (14)  
 Rich, Charles (7)  
 Richards, Ernest W. (2)  
 Richards, Paul S. (16)  
 Richardson, Charles A. (2)  
 Richardson, Emma M. (4)  
 Richardson, Marvin T. (7)  
 Ricketts, Henry E. (7)  
 Rieck, Allan (1)  
 Rieck, Walter R. (9)  
 Riegert, Louis C. (4)  
 Rieman, Aloysius P. (9)  
 Riffin, Irving M. (7)  
 Riggins, Edwin N. (7)

Riley, Philetus H. (14)  
Rineberg, Irving E. (12)  
Ringe, Charles L., Jr. (2)  
Ringewald, Robert H. (2)  
Rinzler, Elliott (7)  
Rinzler, Harry G. (16)  
Ripley, E. Warren (7)  
Ripps, Maurice L. (20)  
Rise, Wilson S. (1)  
Ristine, Edwin R. (4)  
Rita, James J. (11)  
Rizzolo, Edward M. (7)  
Robbin, Lewis (7)  
Robbins, Charles M. (7)  
Robbins, Eugene (7)  
Robbins, Henry B. (9)  
Robbins, Warren D. (5)  
Roberts, Allison H. (7)  
Roberts, Charles D. (2)  
Roberts, Frank A. (7)  
Roberts, Joseph E., Jr. (4)  
Roberts, William A. (7)  
Robertson, Euston S. (7)  
Robertson, Grace M. (20)  
Robie, Theodore R. (7)  
Robins, David (7)  
Robinson, Ernest A. (13)  
Robinson, John T. (18)  
Robinson, Louis H. (7)  
Robinson, Silas E. (2)  
Robinson, William A. (13)  
Rocco, Frank (7)  
Rodman, E. Warren (3)  
Roeber, William J. (7)  
Roemer, Jacob (16)  
Rogers, Dorothy M. (8)  
Rogers, Harry L. (3)  
Rogers, Laurence H. (11)  
Rogers, Robert H. (7)  
Roh, Robert F. (7)  
Romano, Anthony M. (2)

Romano, Patrick J. (7)  
Rommer, Jack J. (7)  
Rona, Maurice (12)  
Roop, William O. (1)  
Rosamilia, Ralph E. (7)  
Rose, Abraham (20)  
Rose, Salvatore J. (7)  
Rose, William G. (11)  
Roseman, Herman I. (7)  
Rosen, Charles D. (7)  
Rosen, Charles E. (9)  
Rosen, Emanuel (7)  
Rosen, Sol (6)  
Rosenbaum, Samuel X. (7)  
Rosenberg, Albert B. (9)  
Rosenberg, Alvin A. (14)  
Rosenberg, Jacob (9)  
Rosenberg, L. Charles (7)  
Rosenberg, Louis (1)  
Rosenberg, Max (7)  
Rosenblatt, Max B. (20)  
Rosenblatt, Sidney (1)  
Rosenstein, Jacob L. (9)  
Rosenstein, Saivel L. (20)  
Rosenthal, Arnold J. (7)  
Rosenthal, Bernice D. (6)  
Rosenthal, Oscar J. (7)  
Rosenthal, Sydney (7)  
Ross, Peter W. (16)  
Ross, Selig J. (2)  
Rossi, Bartolomeo (7)  
Rossi, Gene (18)  
Rost, Adolf S. (7)  
Roth, Oswald H. (7)  
Roth, Samuel R. (7)  
Rothfuss, C. Howard (12)  
Rothhouse, Burnet (7)  
Rothman, Theodore (16)  
Rothschild, Daniel L. (7)  
Rothschild, Karl (12)  
Rothseid, Abraham (7)  
Rowan, Henry M. (11)

Rowland, James J. (13)  
Rowland, John H. (12)  
Rowohl, George O. (2)  
Roy, Bert W. (19)  
Roy, Joseph N. (16)  
RuBacky, Joseph F. A. (16)  
Rubba, Russell R. (1)  
Rube, Joseph A. (2)  
Rubens, Otto (14)  
Rubenstein, Eli (9)  
Rubenstein, Robert (9)  
Rubin, Abraham A. (7)  
Rubin, Adrian D. (13)  
Rubin, Benjamin (12)  
Rubin, David (20)  
Rubin, Henry S. (14)  
Rubin, Samuel (14)  
Rubino, Nicholas M. (7)  
Rubinow, Saul M. (7)  
Rucker, William C. (2)  
Rudolph, John P. (4)  
Ruffer, Ralph A. (9)  
Ruffu, Henry L. (1)  
Rullman, Walter A. (13)  
Rumage, William T. (7)  
Rundlett, Emilie V. (9)  
Runnells, John E. (20)  
Runyan, William J. (7)  
Runyon, Laurance P. (12)  
Ruocco, William B. (16)  
Ruoff, Andrew C. (9)  
Russell, Charles B. (16)  
Russell, David L. (9)  
Russell, Karl S. (4)  
Russo, Dominic T. (18)  
Russomanno, Raymond L. (7)  
Ruttenberg, Louis (8)  
Ruttenberg, Max (4)  
Ruvane, Joseph J. (9)  
Ryley, Harold W. (2)  
Ryman, Merlin T. (14)

#### ASSOCIATE MEMBERS

Richlin, Padie (12)  
Rigeron, D. George (7)

Rowe, Jack M. (7)  
Rowland, Edward G. (11)  
Roylance, F. Dean, Jr. (2)

Rozsa, Stephen (7)  
Rubin, William (12)

## S

#### ACTIVE MEMBERS

Sabarese, Theodore C. (16)  
Sabini, Cecil F. (9)  
Sacco, Anthony G. (9)  
Sacco, Gregory E. (13)  
Sachs, Wilbert (9)  
Sackin, Stanley (11)  
Sadoff, Joseph (20)  
Saffron, Morris H. (16)  
Sager, Harold (9)  
Sala, Aldo W. (16)  
Salasin, Samuel L. (1)  
Salmeri, Edward J. (2)  
Salsberg, Ralph H. (7)  
Saltus, Lloyd S. (14)  
Salvati, Leo H. (20)  
Salway, Benjamin (11)  
Salzman, Nathan (16)  
Samson, Norman D. (7)  
Samter, Max (4)

Samuel, Jerome H. (7)  
Samuels, S. Lawrence (20)  
Sand, Abraham B. (3)  
Sandella, Joseph F. (12)  
Sandler, Moses (2)  
Sandler, Samuel A. (2)  
Sanfacon, Thomas A. (16)  
Santangelo, Emil L. (16)  
Santangelo, Stephen (9)  
Santora, Philip J. (7)  
Santoro, Thomas A. (7)  
Santosky, Benjamin B. (9)  
Saporito, Archibald R. (7)  
Saradarian, Albert V. (9)  
Sargent, Eva R. (18)  
Sarla, Michael (2)  
Saslow, Benjamin I. (7)  
Sasso, Albert (7)  
Satulsky, Emanuel M. (20)

Saulsberry, Charles E. (12)  
Saunders, Orris W. (4)  
Savage, Charles L. (17)  
Savel, Lewis E. (7)  
Sawyer, Blackwell (15)  
Sax, Max T. (7)  
Sayers, Francis P. (17)  
Sayre, William D. (13)  
Sbarra, Francesco C. N. (7)  
Scammell, Frank G. (11)  
Scanlan, D. Ward (1)  
Scasserra, Benedict B. (11)  
Schaaf, Royal A. (7)  
Schaberg, Frank J. (2)  
Schachter, Harry A. H. (7)  
Schaefer, Eugene P. (7)  
Schaefer, Phyllis A. D. (20)  
Schaefer, Marguerite A. (16)  
Schaffer, Barney (7)



- Schaffer, Nathan (7)  
 Schall, Reuben E. (4)  
 Schechtman, Vera (7)  
 Scheer, Eli (9)  
 Scheffler, Wilhelm A. H. (4)  
 Schefrin, Alexander E. (16)  
 Schellenger, Edward A. Y. (4)  
 Scheller, George A. (7)  
 Schenk, Joseph R. (20)  
 Schenker, Benjamin N. (9)  
 Schenker, Israel N. (9)  
 Schepf, Samuel S. (9)  
 Scher, Maurice A. (7)  
 Schildkraut, Jacob M. (11)  
 Schiller, Edwair (20)  
 Schiller, Nicholas (7)  
 Schiller, Rosa O. (20)  
 Schilling, Anthony B. (20)  
 Schiro, S. Robert (2)  
 Schisler, Milton M. (3)  
 Schlein, August (9)  
 Schlein, David (20)  
 Schlichter, Charles H. (20)  
 Schlossbach, Theodore (13)  
 Schlossberg, Ezra (16)  
 Schmidt, Albert F. (13)  
 Schmidt, Clifford M. (19)  
 Schmidt, Walter W. (2)  
 Schmukler, Jacob (7)  
 Schneckenendorf, Samuel J. (9)  
 Schneider, Charles A. (7)  
 Schneider, Clinton R. (15)  
 Schneider, Leo (7)  
 Schneider, Louis (7)  
 Schneider, Louis A. (9)  
 Schoenau, Carl W. (7)  
 Schotland, Clement E. (7)  
 Schrack, Helen F. (4)  
 Schram, William S. (18)  
 Schramm, Joseph A. (7)  
 Schreck, Harry (7)  
 Schretzmann, Rudolph C. (2)  
 Schubert, Roy R. (16)  
 Schuchner, William F. (9)  
 Schuck, Traugott J. (9)  
 Schulman, Abraham S. (9)  
 Schulsinger, Samuel (7)  
 Schulte, Herbert A. (7)  
 Schults, Anna R. (7)  
 Schultz, Augustin M. (16)  
 Schultz, Irving A. (2)  
 Schurman, Emil W. (9)  
 Schurman, Francis H. C. (7)  
 Schwartz, Harold (7)  
 Schwartz, Henry C. (4)  
 Schwartz, Jacob (16)  
 Schwartz, Leon J. (6)  
 Schwartz, Samuel H. (20)  
 Schwartz, William (16)  
 Schwartzberg, Frederick I. (16)  
 Schwarz, Berthold T. D. (9)  
 Schwarz, Henry J. (9)  
 Schwarzkopf, George C. (1)  
 Schweizer, Roman G. (20)  
 Schwinn, Charles (1)  
 Sciarrillo, Louis F. (9)  
 Scielzo, Nicholas F. (16)  
 Scillicri, John (2)  
 Sciorsci, Edward F. (9)  
 Scott, Elmer A. (13)  
 Scott, Frederick J. (19)  
 Scott, Frederick W. (12)  
 Scott, Harold R. (14)  
 Scott, Leonard G. (6)  
 Scott, Parry M. (3)  
 Scott, R. Hunter (7)  
 Scott, Samuel G. (9)  
 Scranton, Charles W. (7)  
 Scribner, Charles H. (16)  
 Scullion, Arthur A. (2)  
 Sealey, Henry J. (2)  
 Seeler, Albert O. (20)  
 Seely, Roy B. (11)  
 Segard, Christian P. (2)  
 Seidler, Victor B. (7)  
 Seidman, Edwin A. (7)  
 Seidman, Joshua I. (7)  
 Seifert, Edwin A. (7)  
 Seiler, Benjamin (2)  
 Seitzick-Robbins, Hannah E. (11)  
 Sekerak, Albert J. (11)  
 Seligmann, Fred S. (9)  
 Selinger, Samuel (9)  
 Sell, Frederick W. (20)  
 Selvaggi, Carlo (7)  
 Sena, Dominic R. (20)  
 Sender, Fannie (12)  
 Senerchia, Fred F., Jr. (20)  
 Serri, William S. (8)  
 Seto, Stanford P. T. (4)  
 Severud, Olaf J. (2)  
 Sewall, Millard F. (6)  
 Seward, Frederic H. (14)  
 Seward, William H. (7)  
 Sewell, Stephen (13)  
 Sexton, Edward V. (2)  
 Seybold, Arthur D. (20)  
 Seymour, Edward T. (2)  
 Seymour, George A. (20)  
 Shack, David N. (7)  
 Shack, Maxwell H. (7)  
 Shaen, Edward (4)  
 Shafer, Albert H. (4)  
 Shafer, F. William (4)  
 Shaner, Ralph D. (7)  
 Shangle, Milton A. (20)  
 Shangold, Jack E. (10)  
 Shanik, William (13)  
 Shannon, James B. (7)  
 Shannon, Lardner M. (7)  
 Shapiro, Charles S. (3)  
 Shapiro, Louis (7)  
 Shapiro, Louis G. (16)  
 Shapiro, Maurice (9)  
 Shapiro, Nathaniel J. (9)  
 Shapiro, Saul J. (9)  
 Sharp, Charles E. (6)  
 Sharp, Reuben L. (4)  
 Shaul, Frederick G. (7)  
 Shaul, John F. (7)  
 Shavelson, Irving C. (1)  
 Shaw, Ernest B. (4)  
 Shaw, John J. (7)  
 Shayeitz, Abraham S. (12)  
 Sheaffer, Clinton P. (4)  
 Shear, M. Murray (11)  
 Shechtman, Abraham (16)  
 Sheehan, Daniel C. (7)  
 Sheeran, Vincent J. (9)  
 Sheets, Cecil C. (8)  
 Sheft, Matthew J. (16)  
 Shemeley, William G., Jr. (4)  
 Shenfeld, Isaac (1)  
 Sheppard, A. G. (6)  
 Sheppard, Frank R. (6)  
 Sheppard, Muse A. (6)  
 Sheppard, Thomas S. (6)  
 Sherk, A. Lincoln (4)  
 Sherman, A. Russell (7)  
 Sherman, Arthur E. (7)  
 Sherman, Benjamin (14)  
 Sherman, Byron G. (14)  
 Sherman, Elbert S. (7)  
 Sherman, Fuller G. (8)  
 Sherman, Samuel H. (20)  
 Sherman, William E. (12)  
 Shevitz, David M. (21)  
 Shill, Benjamin (7)  
 Shimer, A. Burton (1)  
 Shimer, Floyd A. (21)  
 Shinefeld, Maurice A. (16)  
 Shipman, James S. (4)  
 Shipman, Meyer P. (16)  
 Shippee, James N. (16)  
 Shipps, Hammell P. (3)  
 Shirlock, Margaret E. (6)  
 Shirreffs, Russell A. (20)  
 Shivers, Charles H. deT. (1)  
 Shlionsky, Herman (7)  
 Shook, Benjamin E. (9)  
 Shope, Edward P. (4)  
 Shor, David M. (7)  
 Shreehan, Hubert F. (7)  
 Shull, Elliott C. (4)  
 Shull, John V. (12)  
 Shulman, Abraham (16)  
 Shulman, Murray W. (7)  
 Shulman, Nathan L. (9)  
 Shuster, Samuel A. (1)  
 Sica, L. Samuel (11)  
 Sickel, Emanuel M. (15)  
 Sieber, Isaac G. (4)  
 Siegel, Isadore (12)  
 Siegel, Jack G. (7)  
 Siegel, Jacob W. (7)  
 Siegel, Lester (9)  
 Siegel, Sidney L. (6)  
 Siegler, Julius (9)  
 Siemion, Theophilis R. (11)  
 Sigman, George (9)  
 Silich, Robert L. (9)  
 Silk, Charles I. (12)  
 Sill, John B. (11)  
 Silver, E. Drew (11)  
 Silver, Harry B. (7)  
 Silverman, Irving A. (16)  
 Silverman, R. Louis (17)  
 Silverman, S. Andrew (7)  
 Silverman, Theodore M. (20)  
 Silvers, Homer I. (1)  
 Silverstein, Benjamin J. (7)  
 Silverstein, Jacob M. (7)  
 Silverstein, Max (13)  
 Simeone, Peter A. (9)  
 Simkin, Abraham (16)  
 Simmons, Albert V. (7)  
 Simms, George F. (7)  
 Simon, Henry (7)  
 Simon, Julius J. (16)  
 Simon, Ludwig L. (7)  
 Simon, Morris L. (16)  
 Simonson, Louis (7)  
 Simpson, David B. (9)  
 Sims, Richard V., Jr. (20)  
 Sinexon, Henry L. (8)  
 Singer, Bella (20)  
 Singer, Max (7)  
 Singer, Sina S. (9)  
 Singley, Harry P., Jr. (1)  
 Sinkinson, Charles D., Jr. (1)  
 Sinton, John Y. (11)  
 Sirotta, E. Bernard (8)  
 Sisson, Nelson W. (7)  
 Siveke, John (16)  
 Skvarla, John A. (2)

- Skwirsky, Joseph (7)  
Slack, Clarence J. (11)  
Slaff, Florence (16)  
Slavin, Paul (7)  
Sloan, Samuel L. (16)  
Slobodien, Benjamin F. (12)  
Slocum, Harry B. (13)  
Sly, John L. (20)  
Smaine, Enrique delC. (2)  
Small, E. Lester (3)  
Small, Louis (16)  
Smalley, Mahlon C. (18)  
Smith, Alexander L. (9)  
Smith, Andrew M. (1)  
Smith, Arthur B. R. (9)  
Smith, Bertram H. (4)  
Smith, Bryan A. (2)  
Smith, Byron J. (7)  
Smith, Christopher A. (7)  
Smith, Ellis L. (7)  
Smith, Elroy W. (16)  
Smith, George H. (7)  
Smith, Harold W. (7)  
Smith, Henry G. (7)  
Smith, Herman (21)  
Smith, Houghton C. (11)  
Smith, Ivan B. (12)  
Smith, J. Meredith (21)  
Smith, James D. (4)  
Smith, John A. (12)  
Smith, John V. (12)  
Smith, Joseph A. (12)  
Smith, Joseph J. (7)  
Smith, Leon A. (16)  
Smith, Leonard H. (7)  
Smith, Malcolm K. (14)  
Smith, Marcia V. (5)  
Smith, Meyer L. (20)  
Smith, Nehemiah E. (2)  
Smith, Nelson M. (7)  
Smith, Paul E. (11)  
Smith, Percy L. (12)  
Smith, Sydney (12)  
Smith, Thayer A. (7)  
Smith, W. Henley (11)  
Smith, Warren H. (19)  
Smith, Wilbur A. (4)  
Smuda, Alphonse C. (4)  
Snagg, William T. (4)  
Snively, Earl H. (7)  
Snedecor, Spencer T. (2)  
Snegireff, Leonid S. (11)  
Snyder, John E. (9)  
Snyder, W. Jay (9)  
Sobel, I. Jerome (16)  
Sobin, Julius (7)  
Sochacki, Alexander (4)  
Solk, Arthur G. (7)  
Somers, Fred L. (7)  
Somers, Willard H. (2)  
Sommer, George N. J. (11)  
Sommer, George N. J., Jr. (11)  
Sooy, L. Thomas (8)  
Sorock, Emil M. (7)  
Soschin, Samuel J. (7)  
Sosnow, Louis M. (2)  
Spalding, Henry J. (9)  
Spaldo, John L. (18)  
Spallone, Joseph C. (7)  
Spano, Frank (9)  
Sparks, Paul R. (3)  
Spath, William H. (9)  
Spence, Henry (9)  
Spencer, Alvan (14)  
Spencer, Ira T. (12)  
Spencer, James H., Jr. (19)  
Spickers, William (16)  
Spicola, Louis A. (2)  
Spiegelglass, Abraham B. (2)  
Spillane, Timothy H. (21)  
Spinner, Samuel L. (7)  
Spirito, Michael W. (20)  
Spivack, David (20)  
Spohn, Eugene L. (9)  
Spradley, Jeems B. (11)  
Sprague, Edward W. (7)  
Sprague, Seth B. (9)  
Spritzer, Theodore D. (12)  
Spurgeon, Dorsett L. (19)  
Staehle, Richard H. (7)  
Stage, Earl DeW. (14)  
Stahl, Alfred (7)  
Stahl, Charles (7)  
Stamps, G. Ruffin (1)  
Stankiewicz, F. Stanley (9)  
Stanton, Nathaniel B. (20)  
Stark, Harry L. (9)  
Stark, Jacob (16)  
Starr, Benjamin (9)  
Statman, Arthur J. (7)  
Staub, E. Milton (20)  
Steel, John M. (11)  
Steel, William A. (5)  
Steele, Stephen (20)  
Stefansin, Frank (9)  
Steffens, Charles T. (12)  
Stein, Albert (9)  
Stein, Emil (20)  
Stein, George H. (20)  
Stein, Harold M. (16)  
Stein, Isadore (20)  
Stein, Jacob M. (9)  
Stein, Joseph M. (4)  
Stein, Louis A. (11)  
Stein, Martin H. (20)  
Stein, William (12)  
Steinberg, Benjamin L. (16)  
Steinberg, Werner (20)  
Steiner, Edwin (7)  
Stephenson, Daniel H. (4)  
Stephenson, Gordon A. (20)  
Stephenson, Ruth (12)  
Stern, Morris H. (16)  
Steuart, David F. R. (20)  
Stevens, Merton H. (7)  
Stevenson, G. McKay (20)  
Stevenson, George S. (13)  
Stewart, Irving J. (8)  
Stewart, Robert G. (7)  
Stewart, Sloan G. (1)  
Stewart, Walter B. (1)  
Stickles, Lloyd C. (7)  
Stiles, C. Campbell (7)  
Stillwell, Harry C. (20)  
Stinson, Richard (16)  
Stockfish, Robert H. (9)  
Stoddard, Gordon V. (7)  
Stokes, Anthony T. (9)  
Stokes, Earle B. (7)  
Stokes, James S. (16)  
Stokes, Joseph (3)  
Stokes, S. Emilen (3)  
Stoltz, Raymond R. (16)  
Stone, Arthur L. (4)  
Stone, Frank P. (4)  
Stone, Robert G. (11)  
Storaci, Frank S. (11)  
Stout, J. Phillip (9)  
Strack, Vincent J. (7)  
Strahan, Frank G. (13)  
Strasser, Hans A. (7)  
Straub, Herbert H. (7)  
Straughn, Clinton C. (13)  
Straus, Max (7)  
Strauss, Arthur (13)  
Strauss, Clifton J. (20)  
Strauss, Frederick (7)  
Strauss, Max (7)  
Streen, Morris E. (7)  
Street, Daniel B. (9)  
Strelinger, Alexander (20)  
Strom, Abraham (20)  
Stuart, Alexander A. S. (5)  
Stuart, J. Earle (20)  
Stuart, William C. (9)  
Sturchio, Edoardo (7)  
Sturchio, Eugenio (7)  
Stybel, Joseph (20)  
Subin, Harry (1)  
Succoff, Moses C. (16)  
Suesserman, Henry (7)  
Suffness, Gustave (20)  
Sufrin, Emanuel (4)  
Sullivan, Charles J. (12)  
Sullivan, James A. (9)  
Sullivan, John B. (2)  
Sullivan, William M., Jr. (16)  
Sullivan, William T. (7)  
Sulouff, S. Henry (9)  
Summerill, Garnett (4)  
Summers, Alfred D. (11)  
Summey, Thomas J. (3)  
Surgent, George W. (16)  
Surran, Carl A. (1)  
Sussman, Harold (9)  
Suter, Harry F. (17)  
Sutherland, Robert C. (17)  
Sutherland, William W. (16)  
Sutnick, Theodore B. (11)  
Sutton, Harold L. (7)  
Sutton, Joseph G. (7)  
Swain, Richard D., Jr. (7)  
Sweeney, William J. (9)  
Swern, Nathan (11)  
Swertfeger, Herbert W. (11)  
Swiecicki, Martin E. (4)  
Swiney, Juliana C. (9)  
Swiney, Merrill A. (9)  
Symes, Earl R. (7)  
Szerlip, Leopold (7)  
Szold, Norman F. (15)  
Szuch, Nicholas (12)  
Szymanski, John J. (16)

# ASSOCIATE MEMBERS

- Salaky, William L. (12)  
Saracino, Frank J. (7)  
Schirber, Rene G. (12)  
Schwartz, Mortimer L. (7)  
Schwarz, Julianna L. (16)  
Self, Edward B. (7)  
Silbermann, Maximilian (7)  
Silberner, Herbert B. (7)  
Smith, Edward C. (15)  
Sokoloff, Oscar J. (12)  
Solomon, Harold (7)  
Steiner, Herbert (7)

## T

## ACTIVE MEMBERS

- Taber, Frederick S. (12)  
 Taber, Leslie R. (16)  
 Taff, Harry (7)  
 Taffet, William (7)  
 Taft, Herman L. (9)  
 Talmage, William G. (14)  
 Talty, John C. (9)  
 Tanner, Monroe J. (2)  
 Tannert, Carl H. (9)  
 Tansey, William A. (7)  
 Taranto, Michael (20)  
 Tarbell, Harold A. (7)  
 Tataryan, Hovsep (9)  
 Tatem, Henry R., Jr. (4)  
 Tator, Arthur E. (20)  
 Taylor, G. Herbert (7)  
 Taylor, Harold W. (2)  
 Taylor, Malcolm C. (14)  
 Taylor, Raymond A. (15)  
 Taylor, Walter A. (11)  
 Teeter, Charles E. (7)  
 Teichholz, Max H. (16)  
 Tell, M. Edward (16)  
 Teller, Daniel W., Jr. (14)  
 Tellman, Daniel H. (16)  
 Temes, J. Howard (9)  
 Temple, Arthur H. (16)  
 Tenney, Albert S. (7)  
 Tenney, Luman H. (11)  
 Tennis, Edgar M. (2)  
 Terhune, Percy H. (16)  
 terKuile, Reinold W. (2)  
 Terrell, Edward E. (20)  
 Terrieri, D. Joseph (14)  
 Teskey, Stanley (14)
- Tether, Russell K. (2)  
 Thalheimer, Edward J. (6)  
 Thomas, Claude W. (17)  
 Thomas, George N. (6)  
 Thomas, Harry G. (13)  
 Thomas, Irene O. (16)  
 Thomas, John H. (7)  
 Thomas, Ralph B. (9)  
 Thomas, Thomas S., Jr. (14)  
 Thomison, Harry E. (7)  
 Thompson, Arthur F. (7)  
 Thompson, Austin B. (7)  
 Thompson, Edna R. (14)  
 Thompson, Edward C. (16)  
 Thompson, Penrose H. (4)  
 Thompson, Theodore F. (15)  
 Thomson, Carroll S. (7)  
 Thorne, Nathan (3)  
 Thorne, William P. (16)  
 Thornhill, Arthur C. (7)  
 Thornley, William F. (7)  
 Thornton, P. John S. (18)  
 Thron, Leopold E. (16)  
 Tidaback, John D. (20)  
 Tidwell, Harold F. (9)  
 Tilles, Samuel (15)  
 Tillis, Herman H. (7)  
 Timberlake, Baxter H. (1)  
 Timlin, James W. (9)  
 Tirrell, C. Malcolm (7)  
 Toal, Joseph (2)  
 Tobey, Franklin J. (7)  
 Toczek, Heinrich A. (7)  
 Todd, Francis H. (16)  
 Tolomeo, Martin E. (18)  
 Tomauioli, Michele (9)
- Tomec, Otto C. (11)  
 Tomec, Richard F. (7)  
 Tomkins, William (16)  
 Tomlins, Francis I. (2)  
 Tomlinson, Rolland D. (20)  
 Tompkins, Grenelle B. (10)  
 Torppey, John J. (7)  
 Toscano, George A. (2)  
 Towbin, Adolph (15)  
 Townsend, John B. (5)  
 Townsend, Leslie M. (20)  
 Toy, Calvert R. (12)  
 Toye, John E. (7)  
 Tracy, George T. (3)  
 Traganza, Robert W. (4)  
 Trautwein, Charles F. (7)  
 Treiber, Benjamin A. (11)  
 Triarsi, Anthony J. (20)  
 Trippe, Clarence M. (13)  
 Tucker, Sidney (12)  
 Tuers, George E. (16)  
 Turi, Amedeo E. (7)  
 Turner, Charles F. (7)  
 Turner, Isabel B. (2)  
 Tushnet, Leonard (7)  
 Tutela, Arthur C. (4)  
 Tutschulte, Ernest (7)  
 Tweddel, George K. (16)  
 Twitchell, Adelbert B. (7)  
 Tymeson, Walter R. (7)  
 Tyndall, Alice E. (20)  
 Tyndall, Hugh H. (9)  
 Tyndall, Martha W. (20)  
 Tyrrell, George W. (12)  
 Tyson, Frances B. (2)

## ASSOCIATE MEMBERS

- Tansey, William A., Jr. (7)
- Tibor, Albert (7)  
 Tisch, Leon (12)
- Tunis, Benno B. (7)

## U

## ACTIVE MEMBERS

- Udinsky, Hyman J. (16)  
 Uhr, Jacques S. (12)  
 Ulan, Jerome (12)  
 Ulan, Oscar (7)  
 Ulmer, Chester I. (8)
- Ulmer, D. H. Bartine (3)  
 Ulvestad, Lawrence E. (7)  
 Underwood, J. Harris (8)  
 Upham, Helen F. (13)  
 Urbach, George (7)  
 Urbaniak, Henry S. (11)
- Urbanski, Adrian X. (12)  
 Urbanski, Matthew F. (12)  
 Urevitz, Abraham (9)  
 Utkewicz, Edmond A. (9)  
 Uzzell, Edward F. (1)

## V

## ACTIVE MEMBERS

- Vaccaro, Sebastian P. (13)  
 Vaczi, Stephen (11)  
 Vail, William P. (21)  
 Valentin, Irmgard (7)  
 Vallario, Frank A. (7)  
 Vanderbeck, James J. (16)  
 Vanderbeek, Andrew B. (16)
- Vanderbeek, Frank B. (16)  
 Vanderbeek, Stuart W. (2)  
 Vander Clock, Cornelius (16)  
 Vandersluis, Harold H. (2)  
 Vander Veer, H. Garrett (7)  
 Van Dyke, Harry B. (12)  
 Van Dyke, Joseph S. (2)
- Van Eerde, Albert (16)  
 Van Emburgh, George H. (7)  
 Van Gieson, Edward J. (7)  
 Vann, Dorothea D. (2)  
 Vann, Felix H. (2)  
 Vannatta, George W. (7)  
 Vanneman, Joseph S. (11)



Van Ness, H. Roy (7)  
Van Riper, A. Ward (16)  
Van Schott, Gerard J., Jr. (16)  
Van Sciver, John E. L. (4)  
Van Sickle, Albert W. (14)  
Van Urk, Frederick T. (16)  
Van Winkle, Charles I. (2)  
Van Winkle, John S. (16)  
Varney, William H. (21)  
Varriano, John L. (9)  
Vento, Sebastian J. (11)  
Venturo, Ralph C. (8)  
Verbeck, George B. (7)

Vermeulen, Abram (16)  
Villapiano, Joseph G. (13)  
Villegas, Juan A. (2)  
Vincent, Nicholas F. (7)  
Vinciguerra, Michael (20)  
Virgilio, Anthony A. (7)  
Visceglia, Frank R. (16)  
Visconti, Joseph A. (9)  
Vita, Frank J. (2)  
Vitale, Dominic V. (20)  
Viteri, Luis E. (3)  
Vitolo, Ralph E. (20)  
Vogel, H. Austin (20)  
Vol-Tretter, Marta (11)

von Deilen, Henry O. (14)  
Von Hofe, Frederick H. (7)  
Voorhees, Florence E. (7)  
Voorhies, William S., Jr. (14)  
Voorhis, Charles F. (3)  
Vosburgh, Fred (16)  
Voss, J. Landon (14)  
Voss, John C. (3)  
Vostrosablin, Nicholas A. (9)  
Vreeland, Ralph D. (7)  
Vreeland, Ralph J. (16)  
Vreeland, William N. (9)  
Vroom, William L. (2)

#### ASSOCIATE MEMBERS

Van Riper, William D. (2)

Vargyas, Joseph C. (12)

## W

#### ACTIVE MEMBERS

Wacker, William F. (20)  
Wade, Francis A. (14)  
Wade, Simon F. (20)  
Wagner, J. George (3)  
Wagner, Otto (20)  
Wagner, Richard (20)  
Wainright, Melvin A. R. (13)  
Wakeley, William E. (7)  
Waldron, Edward L. (11)  
Waldron, Robert E. (7)  
Walker, Ada H. (6)  
Walker, Harold G. (16)  
Walker, H. Burton (6)  
Walker, Levi M. (1)  
Walker, Robert B. (12)  
Wallace, Marc J. (16)  
Wallach, Bernard (18)  
Wallack, Eli A. (9)  
Wallhauser, Henry J. F. (7)  
Walscheid, Arthur J. (9)  
Walsh, Charles R. (7)  
Walsh, Ronald J. (20)  
Walsh, Thomas J. (11)  
Walsh, Thomas J. (20)  
Walsh, Thomas M. (2)  
Walters, George M. (12)  
Walton, Gordon G. (16)  
Walton, Ralph W. (7)  
Wandall, Frederick G. (8)  
Wangner, William F. (7)  
Warburton, Jack C. (16)  
Ward, Albert J. (14)  
Ward, Elisabeth B. (7)  
Ward, Gertrude P. (7)  
Ward, Leo J. (20)  
Ward, William R. (7)  
Ward, William R., Jr. (7)  
Ware, Carl N. (6)  
Warner, William H. A. (7)  
Warren, Charles B. (2)  
Warren, David E. (16)  
Warren, Earl L. (16)  
Warren, Jacob (16)  
Warter, Peter J. (11)  
Warwick, Ralph A. (4)  
Washburn, Philip C. (14)  
Wassing, Hans (16)  
Waterman, Samuel M. (7)

Waters, Charles H. (11)  
Waters, Edward G. (9)  
Watkins, George R. (4)  
Watkins, Robert E. (13)  
Watman, Anthony J. (9)  
Watov, Samuel E. (11)  
Watson, Frederick S. (11)  
Watts, Wilbur (11)  
Waugh, Bascomb S. (4)  
Way, Clarence W. (5)  
Wayman, Bernard R. (11)  
Webb, Eleanor A. (20)  
Webb, Wilson D. (2)  
Weber, Francis C. (7)  
Weber, John F. (12)  
Weber, Walter D. (9)  
Wechsler, Joseph (9)  
Weeks, Norman E. (7)  
Weems, Don B. (8)  
Wegryn, Louis S. (20)  
Weigel, Charles F. B. (17)  
Weigel, Edgar W. (20)  
Weigel, Elmer P. (20)  
Weimann, Max L. (4)  
Weinberg, Alfred (7)  
Weiner, Henry T. (12)  
Weiner, Samuel E. (1)  
Weinert, Henry V. (16)  
Weinmann, Max H. (7)  
Weinstein, Francis S. (7)  
Weinstein, Morris W. (7)  
Weintraub, William L. (16)  
Weisman, Stephen L. (16)  
Weiss, Abram (9)  
Weiss, Herman (14)  
Weiss, Louis (7)  
Weiss, Morris J. (9)  
Weiss, Selma (7)  
Weissberg, William W. (20)  
Weissman, Meyer T. (20)  
Weithaase, Helen E. (6)  
Welcher, Howard A. (9)  
Welkind, Allen A. (7)  
Weller, Arthur (7)  
Wells, William C. V. (3)  
Weltchek, Herbert (20)  
Wentzell, J. Earl (8)  
West, David H. (4)

West, Edgar L. (11)  
West, Gordon F. (4)  
West, Guernsey F.  
Weston, Heston R. (21)  
Westerhoff, Peter D. (16)  
Western, Frederic B. (20)  
Westney, Alfred W. (1)  
Westney, F. Rolfe (1)  
Weston, Clifford G. (7)  
Wethers, William A. (16)  
Wetterberg, Louis F. (12)  
Whaland, Berta (6)  
Wheeler, James A. V. (9)  
Wheeler, William K. (7)  
Whelan, Edward P. (7)  
Wherry, Elmer G. (7)  
Whims, Clarence B. (1)  
Whinery, Joseph F. (20)  
Whitaker, Henry J. (8)  
White, Frank S. (2)  
White, Harry J. (12)  
White, Hugh M. (9)  
White, R. Rostin (1)  
White, Richard E. (16)  
White, Robert R. (7)  
White, Thomas J. (9)  
Whitcar, John H. (5)  
Whitman, Lloyd B. (2)  
Whittaker, Neil M. (2)  
Wiant, Herman E. (4)  
Widetsky, Alfred (2)  
Wiener, David (7)  
Wiesenfeld, Benjamin (12)  
Wiesler, Howard M. (11)  
Wikoff, John L. (11)  
Wilbur, Franklin L. (13)  
Wilcox, Frank A. (9)  
Wild, Frederick A. (18)  
Wildmann, George A. (11)  
Wilentz, William C. (12)  
Wilkes, LeRoy A. (11)  
Wilkins, Stanley O. (13)  
Willan, Edward H. (7)  
Wiley, F. Parker (7)  
Williams, David P. (14)  
Williams, Frank A. (20)  
Williams, George W. (11)  
Williams, Harry D. (11)

Williams, Hiram (16)  
Williams, John J. (7)  
Williams, Leonard D. (20)  
Williams, Louis E. (14)  
Williams, Raymond A. (1)  
Williams, William C. (2)  
Williamson, William L. (9)  
Willis, Benedict P. (2)  
Willis, Katharen C. (7)  
Willner, Irving (7)  
Willner, Philip (7)  
Willson, James H. (7)  
Wilner, Arthur S. (11)  
Wilner, Irving (11)  
Wilson, Charles W. (6)  
Wilson, Harrison B. (2)  
Wilson, Herbert H. (6)  
Wilson, John H., Jr. (7)  
Wilson, Lawrence A. (1)  
Wilson, Lester R. (4)  
Wilson, Robert B. (13)  
Winn, Samuel L. (1)  
Winslow, John H. (6)

Winter, Carl M. (4)  
Winter, Gladys C. (2)  
Winters, Walter M. (16)  
Wise, Lester D. (13)  
Wishnack, Meyer (16)  
Witkoff, Ben (2)  
Witmer, John D. (12)  
Witte, C. Norman (15)  
Wittenborn, William F. J. (11)  
Woelfle, Henry E. (9)  
Wolbert, Charles M. (9)  
Wolf, Erich (16)  
Wolf, Frank A. (21)  
Wolf, Israel J. (16)  
Wolf, Raymond E. (7)  
Wolfe, Jacob S. (7)  
Wolfe, William W. (7)  
Wolff, Herbert M. (11)  
Wolff, Jerome M. (20)  
Wolfson, Harry (16)  
Wolgin, Philip L. (20)  
Wolowitz, Harry B. (2)  
Woltz, Sidney (9)  
Wood, E. LeRoy (7)

Wood, Oran A. (8)  
Woodman, Charles B. (14)  
Woodruff, Dare (6)  
Woodruff, Ralph G. (13)  
Woodruff, Stanley R. (9)  
Woody, McIver (20)  
Woolf, Bernhardt H. (7)  
Worcester, George F. (2)  
Woronoff, Murray (13)  
Wort, Frederick J. (7)  
Wrench, Alexander E. (7)  
Wright, Herman W. (8)  
Wright, Ralph S. (4)  
Wright, Robert E. (7)  
Wroblewski, Benjamin M. (4)  
Wry, Dean A. (16)  
Wry, Orlin V. (2)  
Wuester, William O. (20)  
Wurts, Margaret M. (7)  
Wurzel, Milton (7)  
Wyatt, Joseph H. (7)  
Wyker, Arthur W. (7)  
Wyman, Edward H. (3)

## ASSOCIATE MEMBERS

Wagner, John (7)  
Walker, Otto (12)

Weinstein, Leopold (7)  
Wilson, Joseph G. (11)  
Winter, Egon W. (7)

Wuerthele, Virginia E. (7)  
Wujciak, Henry J. (7)

## Y

## ACTIVE MEMBERS

Yachnin, Samuel C. (16)  
Yaeger, Leslie A. (11)  
Yager, J. Allen (16)  
Yaguda, Asher (7)  
Yankowicz, Michael (7)  
Yates, Glen L. (7)  
Yates, John S. (16)  
Yeaton, William L., Jr. (9)

Yelin, Gabriel (7)  
Yellin, Charles H. (20)  
Ylvisaker, Lauritz S. (7)  
Yolken, Harry (16)  
Yontef, Reuben (9)  
Yood, Raphael (20)  
York, James L. (2)  
York, Wilbur H. (11)

Yorke, Edward T. (20)  
Yoskalka, Jack S. (7)  
Young, Franklin C. (20)  
Young, George J. (14)  
Young, James L. (18)  
Yuckman, Robert O. (20)  
Yudkoff, William (9)  
Yunck, William P., Jr. (9)

## ASSOCIATE MEMBER

Yeaw, Ralph C. (16)

## Z

## ACTIVE MEMBERS

Zacchino, Arnold A. (2)  
Zager, Saul (7)  
Zalcwski, Irene J. (16)  
Zandt, Frederic B. (11)  
Zapf, Reville D. (8)  
Zappala, John (17)  
Zehnder, A. Charles (7)

Zeitlin, Herman H. (20)  
Ziccardi, Anthony B. (3)  
Zimmer, William (7)  
Zimmerman, Coler (7)  
Zimskind, Joshua N. (11)  
Zingales, Joseph A. (20)  
Zingali, John A. (7)  
Zitani, Alfred M. (9)

Zuck, Arthur C. (21)  
Zuck, John A. (14)  
Zuckerman, David E. (16)  
Zvaifler, Nathan (7)  
Zweibel, Leonard (7)  
Zweigel, Isidore (7)  
Zybulewski, Edmund A. (7)

# MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

## THE MEDICAL SOCIETY OF NEW JERSEY ON MARCH 15, 1942

An asterisk (\*) indicates a deceased member

### ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

#### Active Members

Allman, David B., 104 St. Charles pl., Atlantic City  
Andrews, Clarence L., 1616 Pacific av., Atlantic City  
Axilrod, Maurice H., 2620 Pacific av., Atlantic City  
Barbash, Samuel, 1902 Pacific av., Atlantic City  
Bartlett, Clara K., 4301 Atlantic av., Atlantic City  
Bassett, Norman H., 1616 Pacific av., Atlantic City  
Beir, Ily R., 3900 Atlantic av., Atlantic City  
Bew, Richard C., 1217 Pacific av., Atlantic City  
Boysen, Theophilus H., 100 Phila. st., Egg Harbor  
Bradley, Robt. A., 1616 Pacific av., Atlantic City  
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City  
Carrington, Wm. J., 905 Pacific av., Atlantic City  
Chalfant, W. Paxson, Jr., 7003 Ventnor av., Ventnor  
Charlton, C. Coulter, 124 S. Illinois av., Atlantic C'y  
Clark, S. Worth, 152 S. No. Carolina av., Atlantic C'y  
Cleary, Joseph P., Minotola  
Conaway, Walt P., 1723 Pacific av., Atlantic City  
Corson, Filbert R., 101 S. Indiana av., Atlantic City  
Coward, Edwin H., P. O. Box 666, Pleasantville  
Crane, Bernard, 306 Pacific av., Atlantic City  
Dalton, S. Eugene, 117 S. Illinois av., Atlantic City  
Davidson, Harold S., 101 S. Indiana av., Atlantic C'y  
Davis, Byron G., 1500 Pacific av., Atlantic City  
Davis, W. Cole, 109 S. Portland av., Ventnor  
deHellebranth, Roland T., 104 S. Fr'nkft av., Ventn'r  
diNicholant, Vincent J., 3121 Atlantic av., Atl.City  
Diskan, Samuel M., 1904 Pacific av., Atlantic City  
Donnelly, William A., 1616 Pacific av., Atlantic City  
Durham, Robt. B., 130 S. Illinois av., Atlantic City  
Durham, Royal E., 100 S. New Haven av., Ventnor  
Dyer, Edward H., 102 S. Victoria av., Ventnor  
Eckert, Walter L., College av., Haverford, Pa.  
Elliott, Frazier J., 10 N. Second st., Hammonton  
Erber, Leonard B., 2703 Pacific av., Atlantic City  
Ewens, Arthur E., 3600 Pacific av., Atlantic City  
Feinstein, Louis, 410 Pacific av., Atlantic City  
Fish, Clyde M., 7 W. Washington av., Pleasantville  
Fox, Wm. W., 101 S. Indiana av., Atlantic City  
Frank, Myrtille, 227 Philadelphia av., Egg Harbor C'y  
Frank, Perry, 227 Philadelphia av., Egg Harbor  
Goldstein, Samuel, 16 E. Main st., Mays Landing  
Gordon, Benjamin L., 1616 Pacific av., Atlantic City  
Gordon, Samuel F., 2005 Pacific av., Atlantic City  
Gottlieb, Morris, 9 S. Swarthmore av., Atlantic City  
Grier, Robt. M., 50 E. Washington av., Pleasantville  
Gross, Max, 109 States av., Atlantic City  
Gruhler, Jean A., 5407 Atlantic av., Ventnor  
Guion, Edward, Shore rd., Northfield  
Halpern, Samuel, 504 Pacific av., Atlantic City  
Harley, Halvor L., 101 S. Indiana av., Atlantic City  
Harris, Wm. O., 32 N. New Jersey av., Atlantic City  
Henderson, Kenneth P., Ansley Park, Pleasantville  
Hersohn, Wm. W., 116 S. Illinois av., Atlantic City

Hess, L. Elmore, 19 E. Bolton av., Absecon  
Hoffman, Harry S., 3302 Pacific av., Atlantic City  
Holoman, M. Browne, 1 No. Haverford av., Margate  
Holt, Edward Z., 4100 Atlantic av., Atlantic City  
Hudson, Howard S., Camp Croft, S. C.  
Hudson, Woodburn J., 39 E.W'sh'gton av., Pl'santv'le  
Hyman, Chas., 2619 Pacific av., Atlantic City  
Infield, Gerald L., 1401 Shore rd., Northfield  
Irvin, John S., 1910 Pacific av., Atlantic City  
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City  
Johnson, V. Earl, 101 S. Indiana av., Atlantic City  
Kahn, Leo, 32 States av., Atlantic City  
Kaighn, Chas. B., 905 Pacific av., Atlantic City  
Kilduffe, Robt. A., Atlantic City Hosp., Atlantic City  
Kline, Herman, 2643 Pacific av., Atlantic City  
Krechmer, Abraham, 400 Pacific av., Atlantic City  
Leonard, Isaac E., 2842 Atlantic av., Atlantic City  
Leonard, Isaac E., Jr., 2842 Atlantic av., Atlantic C'y  
Madden, Leland S., 21 E. Verona av., Pleasantville  
Magill, Marcus, 4116 Ventnor av., Atlantic City  
Major, Morton M., 4212 Ventnor av., Atlantic City  
Marshall, H. Donald, 707 N. Indiana av., Atlantic C'y  
Marvel, Peter H., 2216 Shore rd., Northfield  
Mason, James H., 1616 Pacific av., Atlantic City  
Mathis, John H., 121 S. Illinois av., Atlantic City  
McGeehan, Stanley M., 6505 Atlantic av., Ventnor  
McGivern, Chas. S., 5407 Atlantic av., Ventnor  
Merendino, Anthony G., 2720 Pacific av., Atlantic C'y  
MeVay, James C., 2907 Pacific av., Atlantic City  
Milanor, Cesare, 1 S. Brighton av., Atlantic City  
Mishler, Jay E., 805 Pacific av., Atlantic City  
Molitch, Matthew, 705 Pacific av., Atlantic City  
Murray, Clifford K., 7103 Ventnor av., Ventnor  
Nickman, E. Harrison, 4702 Atlantic av., Atlantic C'y  
Pennington, John, 101 S. Indiana av., Atlantic City  
Perez, John F., 2518 Arctic av., Atlantic City  
Pilkington, Albert, 117 S. Virginia av., Atlantic City  
Poland, Geo. A., 206 E. Verona av., Pleasantville  
Quinn, Norman J., 3303 Pacific av., Atlantic City  
Read, Hilton S., 5407 Atlantic av., Ventnor  
Repici, Anthony J., 107 N. 3rd st., Hammonton  
Reynor, Daniel C., 2703 Pacific av., Atlantic City  
Rieck, Allan, 507 S. Shore rd., Pleasantville  
Rise, Wilson S., 4502 Ventnor av., Atlantic City  
Roop, William O., 101 S. Indiana av., Atlantic City  
Rosenberg, Louis, 26 S. Stenton pl., Atlantic City  
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City  
Rubba, Russell R., 21 Horton st., Hammonton  
Ruffu, Henry L., 111 S. Boston av., Atlantic City  
Salasin, Samuel L., 511 Pacific av., Atlantic City  
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City  
Schwarzkopf, Geo. C., 2901 Pacific av., Atlantic City  
Schwinn, Chas., 7600 Winchester av., Margate City



Shavelson, Irving C., 3822 Ventnor av., Atlantic City  
Shenfeld, Isaac, 4806 Atlantic av., Ventnor  
Shimer, A. Burton, 606 Pacific av., Atlantic City  
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City  
Shuster, Samuel A., 101 S. Rhode Island av., Atl. C'y  
Sillers, Homer I., 16 S. Suffolk av., Ventnor  
Singley, Harry P., Jr., 100 S. Stratford av., Ventnor  
Sinkinson, Chas. D., Jr., 1616 Pacific av., AtlanticC'y  
Smith, Andrew M., 344 Philadelphia av., Egg Harbor  
Stamps, G. Ruffin, 300 E. Verona av., Pleasantville  
Stewart, Sloan G., N. Caro. and Pac. avs., Atl. City  
Stewart, Walter B., 8 N. Tallahassee av., AtlanticC'y  
Winn, Samuel L., 1616 Pacific av., Atlantic City

Subin, Harry, 1616 Pacific av., Atlantic City  
Surran, Carl A., 1616 Pacific av., Atlantic City  
Timberlake, Baxter H., 1616 Pacific av., AtlanticC'y  
Uzzell, Edward F., 2703 Pacific av., Atlantic City  
Walker, Levi M., 110 S. No. Carolina av., Atl. City  
Weiner, Samuel E., 904 Pacific av., Atlantic City  
Westney, Alfred W., 3005 Pacific av., Atlantic City  
Westney, F. Rolfe, 1920 Pacific av., Atlantic City  
Whims, Clarence B., 5401 Ventnor av., Ventnor  
White, R. Rostin, 644 Shore rd., Somers Point  
Williams, Raymond A., 7207 Atlantic av., Ventnor  
Wilson, Lawrence A., 114 N. Shore rd., Absecon

Number of Active Members and basis of representation, 131.

#### Honorary Members

Marcus, Joseph H., Atlantic City

Martin, William, Atlantic City

### BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

#### Active Members

Agáyoff, John D., 127 S. Washington av., Bergenfield  
Alexander, Samuel, 12 S. Main st., Park Ridge  
Alexander, Stewart F., Edgewood Arsenal, Md.  
Anderson, Reuben M., 408 Main st., Hackensack  
Angelillis, Paul, 76 State st., Hackensack  
Angiolitti, Louis V., 2014 Hoyt av., Fort Lee  
Appold, George D., 60 E. Church st., Bergenfield  
Baketal, H. Sheridan, 155 Van Wagenen av., Jer.C'y  
Baldwin, John F., 1474 Windsor rd., W. Englewood  
Balze, Henry R., 147 Christie st., Leonia  
Banta, Raymond E., 30 Engle st., Tenafly  
Barbash, Roslyn H. W., 835 Red rd., Teaneck  
Barlow, G. Barton, 157 Engle st., Englewood  
Barnes, Wm. J., 155 Engle st., Englewood  
Baron, Herbert A., 150 Terrace av., Hasbr'k Heights  
Basralian, Joseph B., 238 Blvd., Hasbrouck Heights  
Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge  
Berke, Raynold N., 430 Union st., Hackensack  
Bernard, Richard C., 241 Outwater Lane, Garfield  
Beyer, William, Jr., 612 Undercliff av., Edgewater  
Bickner, Alvah W., 84 Park av., Rutherford  
Black, LeRoy W., 33 W. Passaic av., Rutherford  
Blauvelt-Wells, Grace B., 76 Heights rd., Ridgewood  
Bleasby, Charles B., 136 Passaic av., Garfield  
Blenkle, Victor A., 140 Chadwick rd., Teaneck  
Bono, Joseph J., 68 Tenafly rd., Englewood  
Bookstaver, Barnet S., 193 Norma rd., Teaneck  
Bosch, Taeke, 290 E. Franklin Turnpike, Hohokus  
Branon, Mark E., 16 W. Passaic av., Rutherford  
Bregman, Alexander, 2 Dempsey av., Edgewater  
Brennan, Alfred T. V., Jr., 275 Engle st., Englewood  
Brown, John L., 647 Anderson av., Grantwood  
Brown, Leonard, 190 Park st., Ridgefield Park  
Buckley, Paul J., 159 Palisade av., Bogota  
Bump, Samuel C., 65 N. Maple av., Ridgewood  
Burnham, Lyman, 229 Engle st., Englewood  
Burns, Geoffrey C. H., County rd., Demarest  
Busicco, Philip S., 131 Liberty rd., Englewood  
Calabrese, D. John, 139 Rochelle av., Rochelle Park  
Campbell, James M., 101 S. Central av., Ramsey  
Candio, Vincent P., 347 Ridge rd., Lyndhurst  
Carbone, Ralph, 501 Marlboro rd., Wood-Ridge  
Carroll, Thomas R., 754 Anderson av., Cliffside Park  
Cartneck, Louis C., 228 Hillcrest av., Wood-Ridge  
Caruso, Paul F., 196 Hackensack st., Wood-Ridge  
Casciano, Adolph D., 42 Ridgefield av., Ridgefield P'k

Catania, Joseph P., 140 Passaic st., Garfield  
Chase, Kalman, Jr., 80 Sheridan av., Hohokus  
Clarie, D'Arcy C., 558 Broad av., Ridgefield  
Clarke, Edward W., 435 Warwick av., W. Englew'd  
Cloud, Albert W., 139 Huguenot av., Englewood  
Cochrane, Cleland D., Main st., Closter  
Connor, Clarence A., 1586 Center av., Fort Lee  
Cooke, H. Hamilton, 100 Prospect st., Ridgewood  
Cooper, Howard M., 37 Ridge rd., Rutherford  
Coppoletta, Jos. M., 452 Palisade av., Cliffside Park  
Corn, David, 119 Park st., Ridgefield Park  
Costabile, Vincent, 150 Ridge rd., Lyndhurst  
Coughlin, Joseph J., 840 Queen Ann rd., Teaneck  
Crandall, John K., 200 Main st., Fort Lee  
Cropsey, Chas. D., 168 Chestnut st., Rutherford  
Curtis, Donald A., 241 Union st., Hackensack  
D'Agostin, Henry, 243 Fulton ter., Cliffside Park  
D'Amato, Charles R., 324 Hoboken rd., E. Rutherford  
Dayton, Spencer T., 86 W. Demarest av., Englewood  
DeBlasio, Cornelius V., 9 W. Park pl., Rutherford  
Decker, John G., 216 Blvd., Hasbrouck Heights  
Demarest, J. Willis, 124 Elm av., Hackensack  
DeSanto, A. M., Summit av. and Essex st., Hack'ns'k  
Deuell, William D., 190 Elm av., Hackensack  
Dezer, Chas. N., Jr., 210 Main st., Hackensack  
Dickson, John D., 202 Larch av., Bogota  
Dilger, Frederick G., 210 Main st., Hackensack  
Edgerly, Sherburne E., 185 E. Palisade av., Englew'd  
Edwards, J. Bennett, 144 Woodridge pl., Leonia  
Ellmers, Basil J., 304 Milford av., New Milford  
Essertier, Edward P., 273 State st., Hackensack  
Evans, J. Lawrence, Jr., 254 Christie Hts. st., Leonia  
Fadden, Francis J., Jr., 275 Engle st., Englewood  
Farmer, Vincent, 288 State st., Hackensack  
Farr, Walter J., 288 Griggs av., Teaneck  
Fechner, Fred J., 846 Garrison av., Teaneck  
Ferrari, Andrew F., 110 Hackensack st., E.Ruth'rd  
Fietti, Vincent G., 112 Ridge rd., Lyndhurst  
Finke, George W., 237 State st., Hackensack  
Finke, John H. D., 19 Hudson st., Hackensack  
Fitzhugh, Wm. F., 190 Euclid av., Ridgefield Park  
Fitzpatrick, Leo J., 134 Bergen av., Ridgefield Park  
Fliegel, Wm. M., 85 W. Passaic st., Maywood  
Forte, F. Chester, 111 State st., Hackensack  
Freeland, Frank, 281 State st., Hackensack  
Friedman, Abraham I., 280 State st., Hackensack

- Gatti, Joseph D., 285 State st., Hackensack  
Gershman, Jos. G., 185 E. Madison av., Dumont  
Gilady, Raphael, 205 Union st., Hackensack  
Giordano, William C., 855 Broad av., Ridgefield  
Gittelsohn, Isador, 896 Kinderkamack rd., RiverEdge  
Gitterman, David A., 519 Engle st., Englewood  
Giudice, Vincent W., Harrison av., Waldwick  
Gladstone, Albert L., 404 Hickory av., Paramus  
Goldberg, David, 7 Bogert pl., Westwood  
Goldfarb, Abraham, 52 Chestnut st., Rutherford  
Gould, Werner, 219 Passaic st., Hackensack  
Gramsch, A. Louis, Bergen Pines, Oradell  
Greenfield, Arthur W., 50 Anderson st., Hackensack  
Greenfield, Wm. J., 50 Anderson st., Hackensack  
Groff, Parker A., 159 Washington av., Little Ferry  
Grueninger, Edward F., 24 Columbia av., Cliffside Pk  
Hallett, Frederick S., 200 Passaic st., Hackensack  
Halpern, Herman, 143 Engle st., Englewood  
Halpern, Jesse O., 135 E. Madison av., Dumont  
Harryman, Wm. K., 271 Union st., Hackensack  
Hawes, Vernon L., 63 Church st., Ramsey  
Helff, Joseph R., 1367 Teaneck rd., W. Englewood  
Heller, Geo., 460 Engle st., Englewood  
Hensle, Otto S., 5 Pangborn pl., Hackensack  
Hillsman, R. Bryan, 268 Vandelinda av., Teaneck  
Hirsch, John J., 191 Wallington av., Wallington  
Hitzemann, Louis A., 30 E. Passaic st., Maywood  
Horowitz, Herman J., 872 Broad av., Ridgefield  
Hull, Donald B., 88 W. Ridgewood av., Ridgewood  
Irwin, John H., 51 Tenafly rd., Englewood  
Jacobitti, Edmund E., 491 Maywood av., Maywood  
Jenkins, Alvah R., 40 Armory st., Englewood  
Johnson, G. Leonard, 390 Booth av., Englewood  
Johnston, Rufus O., Parkside rd., Harrington Park  
Johnston, Sidney F., 365 Rochelle av., Rochelle Park  
Jordan, Walter L., 145 Engle st., Englewood  
Jukofsky, Isidore D., 32 Union pl., Ridgefield Park  
Kakascik, Emil J., 206 Palisade av., Garfield  
Kastler, Franz, 54 Ames av., Rutherford  
Keir, Floyd E., 308 Engle st., Englewood  
Kennedy, Paul A., 147 Tenafly rd., Englewood  
King, Chester A., 412 Kinderkamack rd., Oradell  
Kingslow, George L., 346 First st., Hackensack  
Kissinger, Donald J., 120 E. Madison av., Dumont  
Klostermann, Julius A., 40 Maple av., Bogota  
Knapp, Richard E., 25 Hudson st., Hackensack  
Knight, Wm. T., 515 Oradell av., Oradell  
Knowles, George M., 241 Main st., Hackensack  
Knox, Charles A., 138 Bergen av., Ridgefield Park  
Knox, Harriet L., 390 Union st., Hackensack  
Kraissl, Cornelius J., 393 Main st., Hackensack  
Kralick, Louise C., 248 Terrace av., Hasbrouck Hts.  
Latona, Joseph A., 78 Main st., Lodi  
Legato, Samuel F., 417 Palisade av., Cliffside Park  
Lemmerz, Willard H., 184 Hackensack st., W'd-Ridge  
Lesko, Stephen W., 234 Mt. Pleasant av., Wallington  
Levy, Jack D., 191 Union st., Hackensack  
Lewis, Alice B., E. Saddle River rd., Saddle River  
Littwin, Chas., 950 Queen Ann rd., Teaneck  
Liva, Arcangelo, 5 Pangborn pl., Hackensack  
Liva, G. Albin, Madison av., Wyckoff  
Liva, Paul F., 230 Stuyvesant av., Lyndhurst  
Loman, Sam'l G., 130 Magnolia av., Cresskill  
Lombardi, Frank L., 25 E. Clinton av., Bergenfield  
Lord, C. Donald, 496 S. Maple av., Glenrock  
Lueddecke, Roland E., 216 Randolph av., E. R'th'rf'd  
Luria, Sanford A., 249 Queen Anne rd., Bogota  
Lynch, Maurice M., 396 Union st., Hackensack  
Lyons, Romola L. K., 171 Meadowbr'd rd., Englew'd  
Macaulay, Francis A., 815 Elm av., Teaneck  
MacKellar, James M., 26 E. Clinton av., Tenafly  
MacLaren, Philip J., 397 Kinderkamack rd., Westw'd  
Madden, Russell F., 372 Park st., Hackensack  
Mader, A. Ivan, Jr., 430 Union st., Hackensack  
Mancene, Edward M., 145 Marshall av., Little Ferry  
Markley, Luther A., Holy Name Hosp., Teaneck  
Marx, Frederick J., 539 Kinderkamack rd., RiverEdge  
McCormack, Frank C., 95 Tenafly rd., Englewood  
McFeely, Percy R., 242 Palisade av., Bogota  
McGuire, Joseph T., 77 Autumn st., Lodi  
McLane, A. Donald, 498 Engle st., Englewood  
Mears, William G., 222 Overlook av., Leonia  
Megibow, Harold J., 43 Arch st., Ramsey  
Metz, Henry, 384 Fairmount av., Jersey City  
Meyer, Howard M., 400 Maple Hill dr., Hackensack  
Miller, Herbert G., 330 Mortimer av., Rutherford  
Mockett, Walter W., 714 Palisade av., Grantwood  
Modrys, Walter F., 1400 Palisade Plaza, Hudson Hts.  
Mores, Herbert R., 65 Bergen av., Ridgefield Park  
Morrow, Joseph R., Bergen Pines, Oradell  
Mosher, Henry L., 325 Valley Brook av., Lyndhurst  
Muller, Frederick L., 413 Third st., Carlstadt  
Mulligan, Luke A., 230 Central av., Leonia  
Myers, Norman V., 41 Magnolia av., Tenafly  
Neary, Edward R., 1 W. Harriet av., Palisades Park  
Netz, Lester W., 414 Main st., Hackensack  
Neville, Robert J., 547 Main st., Hackensack  
Nichols, Frank I., 52 Euclid av., Hackensack  
Nicol, Lorenz C., 360 Larch av., Bogota  
O'Brien, Paul, 196 Main st., E. Rutherford  
Olpp, John L., 100 E. Palisade av., Englewood  
Oren, Hyman, Park av., Park Ridge  
Padden, Aloysius F., 66 Queen Ann rd., Bogota  
Pagano, Peter, 324 Franklin av., Ridgewood  
Pallen, Conde DeS., 412 Main st., Hackensack  
Patti, Frank A., 241 Broad av., Leonia  
Payne, Joseph, 223 Godwin av., Midland Park  
Pedevill, Joseph R., 232 Highland av., Palisades Pk  
Perham, Roy G., 248 Boulevard, Hasbrouck Heights  
Pettit, Harry H., 138 Franklin av., Ridgewood  
Phillips, Walter, 109 E. Palisade av., Englewood  
Pierce, Henry A., 150 Broad av., Leonia  
Pignitore, Eufelia, 30 Martin ter., Hackensack  
Pitkin, Geo. P., 170 S. Washington av., Bergenfield  
Placa, James A., 112 Prospect st., Ridgewood  
Policastro, Nelson C., 378 Union st., Hackensack  
Prall, Henry E., 755 Anderson av., Cliffside Park  
Prather, Charles G., 260 Westwood av., Westwood  
Prather, John W., 155 N. Washington av., Dumont  
Protzman, Thomas B., 408 Conrad rd., Englewood  
Prout, Wm. B., 88 W. Forrest av., W. Englewood  
Pullen, Guy F., 111 Leonia av., Leonia  
Rader-Hoheb, Katherine, 5 Lincoln av., Rutherford  
Ravits, Everitt C., 13-29 River rd., Fairlawn  
Reich, Samuel B., 286 Union st., Hackensack  
Reid, Erwin W., 125 Marsellus pl., Garfield  
Reilly, David F., Bergen Pines, Oradell  
Reinhold, H. E., 441 W. Englewood av., W. Englew'd  
Richards, Ernest W., 374 DeWolf pl., Hackensack  
Richardson, Charles A., Main st., Closter  
Ringe, Charles L., Jr., 786 Palisade av., Teaneck  
Ringewald, Robert H., 284 Broad av., Leonia  
Robert's, Charles D., 71 Chestnut st., Englewood  
Robinson, Silas E., Franklin Turnpike, Waldwick  
Romano, Anthony M., 332 Liberty av., Hillsdale  
Ross, Selig J., 507 N. Blvd., Richmond, Va.  
Rowohl, George O., 175 Washington av., Dumont  
Rube, Joseph A., 145 Prospect st., Ridgewood  
Rucker, William C., 408 Main st., Hackensack  
Ryley, Harold W., 1 Lincoln pl., E. Rutherford  
Salmeri, Edward J., 500 Marlboro rd., Wood-Ridge  
Sandler, Moses, 2013 Center av., Fort Lee  
Sandler, Samuel A., 70 Anderson st., Hackensack  
Sarla, Michael, 55 Hudson st., Hackensack  
Schaberg, Frank J., 154 Blvd., New Milford  
Schiro, S. Robert, 209 Roosevelt av., Hasbrouck Hts.  
Schmidt, Walter W., 386 Palisade av., Cliffside Park  
Schretzmann, Rudolph C., 60 Donaldson av., Ruth'rf'd  
Schultz, Irving A., 31-11 Broadway, Warren Point  
Scillieri, John, 811 E. 22nd st., Paterson



Scullion, Arthur A., 460 Anderson av., Cliffside P'k  
Sealey, Henry J., 79 S. Washington av., Dumont  
Segard, Christian P., 204 Glenwood av., Leonia  
Seiler, Benjamin, 580 Palisade av., Cliffside Park  
Severud, Olaf J., 5 Pangborn pl., Hackensack  
Sexton, Edward V., 936 Queen Anne rd., Teaneck  
Seymour, Edward T., 55 Hillside av., Tenafly  
Skvarla, John A., 17 Koster st., Wallington  
Smaine, Enrique delC., 502 Summit av., Carlstadt  
Smith, Bryan A., 20 West Plaza, Ridgewood  
Smith, Nehemiah E., 33½ Humphrey st., Englewood  
Snedecor, Spencer T., 50 Anderson st., Hackensack  
Somers, Williard H., 157 Engle st., Englewood  
Sosnow, Louis M., 51 Central av., Hillsdale  
Spicola, Louis A., 343 Union st., Lodi  
Spiegelglass, Abraham B., 417 Main st., Hackensack  
Sullivan, John B., 541 Page av., Lyndhurst  
Tanner, Monroe J., Paramus  
Taylor, Harold W., 247 Mountain road, Englewood  
Tennis, Edgar M., 375 Engle st., Englewood  
terKuile, Reinold W., 88 W. Ridgew'd av., Ridgew'd  
Tether, Russell K., Main st., Closter  
Toal, Joseph, 803 Prospect av., Ridgefield  
Tomlins, Francis I., 20 S. Irving st., Ridgewood  
Toscano, George A., 305 Union st., Hackensack  
Turner, Isabel B., 141 Sheffield av., Englewood  
Zacchino, Arnold A., 1001

Tyson, Frances B., 101 Leonia av., Leonia  
Vanderbeek, Stuart W., 143 Engle st., Englewood  
Vandersluis, Harold H., 86 S. Main st., Park Ridge  
Van Dyke, Jos. S., 42 Palisade Blvd., Palisades P'k  
Vann, Dorothea D., 63 Spring lane, Englewood  
Vann, Felix H., 63 Spring Lane, Englewood  
Van Winkle, Charles I., 79 Ridge rd., Rutherford  
Villegas, Juan A., 406 Lafayette av., Cliffside Park  
Vita, Frank J., 695 Palisade av., Cliffside Park  
Vroom, Wm. L., 88 W. Ridgewood av., Ridgewood  
Walsh, Thomas M., 210 Kipp av., Hasbrouck Hgts.  
Warren, Charles B., 181 Prospect av., Bergenfield  
Webb, Wilson D., 316 State st., Hackensack  
White, Frank S., 916 Red rd., Teaneck  
Whitman, Lloyd B., 7 West Clinton av., Bergenfield  
Whittaker, Neil M., 418 Main st., Hackensack  
Widetsky, Alfred, 85 Broadway, E. Paterson  
Williams, William C., 9 Ridge rd., Rutherford  
Willis, Benedict P., 185 Montross av., Rutherford  
Wilson, Harrison B., 430 Union st., Hackensack  
Winter, Gladys C., 717 Norma court, Teaneck  
Witkoff, Ben, 215 Terrace av., Hasbrouck Heights  
Wolowitz, Harry B., 20 Spring Valley av., Hack'ns'k  
Worcester, George F., 220 Engle st., Englewood  
Wry, Orlin V., 95 High st., E. Rutherford  
York, James L., 331 River rd., New Milford  
Anderson av., Palisade

#### Number of Active Members and basis of representation, 295.

##### Associate Members

Pizzi, Peter J., 323 Harrison av., Garfield  
Roylance, Fidean, Jr., Closter Med. Group, Closter  
Van Riper, William D., 314 Engle st., Englewood

##### Courtesy Members

Burt, C. Vincet, New York City  
Coca-Fernandez, Arthur, Oradell  
Denison, Ward C., Ridgewood  
Hambright, Arthur M., Ramsey  
Harreys, Charles W., Ridgewood  
Hickey, Charles M., New York  
Liddy, Frank J., Mahwah  
Lowry, Thomas, Ridgewood  
Opitz, Russell B., Palisade  
Randazzo, Anton P., Passaic  
Spickers, William, Paterson  
Twinem, Francis P., New York City

##### Honorary Members

Burbank, Hugh E., Lyndhurst  
Proctor, James W., Tenafly  
Clock, Ralph O., Scarsdale, N. Y.  
Tidwell, George W., Wallington

##### Transfers

Severud, Olaf J., from New York County  
Klosterman, Julius A., from New York County

## BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Thursday evening of each month, except June, July and August. Annual Meeting in November.

##### Active Members

Anderson, Richard D., 465 High st., Burlington  
Betts, R. Winfield, 22 N. Main st., Medford  
Bray, William E., 41 Elizabeth st., Pemberton  
Busansky, Samuel T., Circle dr., Browns Mills  
Conroy, John S., 124 E. Broad st., Burlington  
Curtis, Howard C., 224 E. Main st., Moorestown  
Darlington, Emlen P., New Lisbon  
Davis, E. Vernon, 63 Mill st., Vincentown  
Davis, Jacob M., 1400 High st., Burlington  
Dickson, T. Bruce, 408 Main st., Riverton  
Downs, Roscius I., 40 Scott st., Riverside

Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly  
Frank, Reuben, 108 Hanover st., Pemberton  
Geary, Russell D., 337 Bridgeboro rd., Riverside  
Haines, Edgar J., 45 S. Main st., Medford  
Haldeman, Robert E., 34 Garden st., Mt. Holly  
Hartman, Luther M., 111 E. Main st., Maple Shade  
Hebble, Howard M., 129 Chester av., Moorestown  
Hogan, Carlton P., 207 E. Union st., Burlington  
Hornberger, J. Howard, Fourth & Main sts., Roebling  
Hunter, Edward R., 321 Union av., Delanco  
Imhoff, Robert E., 29 E. Main st., Moorestown



Kuder, Joseph M., 104 Garden st., Mt. Holly  
LeFavor, Dean H., 619 Morgan av., Palmyra  
Longsdorf, Harold E., 200 Garden st., Mt. Holly  
Love, Elizabeth F., 142 E. Oak av., Moorestown  
Lucas, W. Fred, 23 W. Broad st., Burlington  
Mark, Harry B., 600 Elm ter., Riverton  
McDonnel, Gerald E., 41 Cherry st., Mt. Holly  
Mendenhall, Clinton D., 412 Farnsw'th av., B'rd'nt'n  
Metzer, Emma P. W., 430 Fairview st., Riverside  
Metzer, Freeman W., 428 Fairview st., Riverside  
Meyer, Eugene A., 407 Chester av., Moorestown  
Mills, Charles S., 106 Lippincott av., Riverton  
Muldoon, Edward J., 200 3rd st., Florence  
Munro, Charles A., Main st., Marlton  
Newcomb, Marcus W., Browns Mills  
Newmeyer, Joseph, 739 Chestnut st., Delanco  
Peacock, Arthur B., 39 W. Main st., Columbus  
Remer, Daniel F., 417 High st., Mt. Holly  
Rodman, E. Warren, 503 Cooper st., Beverly  
Rogers, Harry L., 408 Main st., Riverton

Sand, Abraham B., 454 High st., Burlington  
Schisler, Milton M., 2nd & Church sts., Florence  
Scott, Parry M., 466 Cooper st., Beverly  
Shapiro, Charles S., S. Forklanding rd., Maple Shade  
Shippo, Hammell P., 739 Chestnut st., Delanco  
Small, E. Lester, 30 Branch st., Medford  
Sparks, Paul R., 102 W. Broad st., Burlington  
Stokes, Joseph, 220 E. Main st., Moorestown  
Stokes, S. Emlen, 129 Chester av., Moorestown  
Summey, Thomas J., 800 Golf View rd., Moorestown  
Thorne, Nathan, 119 Chester av., Moorestown  
Tracy, George T., 222 Warren st., Beverly  
Ulmer, D. H. B., 199 Chestnut st., Moorestown  
Viteri, Luis E., 214 High st., Mount Holly  
Voorhis, Charles F., 330 Morgan av., Palmyra  
Voss, John C., 634 Thomas av., Riverton  
Wagner, J. George, Riverbank, Delanco  
Wells, William C. V., 220 Hazel av., Delanco  
Wyman, Edward H., 100 W. Pearl st., Burlington  
Ziccardi, Anthony V., 210 W. Main st., Maple Shade

**Number of Active Members and basis of representation, 62.**

**Honorary Members**

Bauer, Harry W., Palmyra

Wilkinson, George H., Moorestown

**Resigned**

Siddall, John R., Riverton

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**CAMDEN COUNTY (4)**

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June.  
Annual Meeting in May.

**Active Members**

Anderson, Wm. M., 20 Kings H'way, W., Haddonf'd  
Andrus, David L., 805 Cooper st., Camden  
Asbell, Nathan, 326 Cooper st., Camden  
Athey, Kenneth L., 3616 Westfield av., Camden  
Baker, Banks S., 618 Benson st., Camden  
Baker, Maurice E., 1149 Kaighn av., Camden  
Barb, Kirk B., 1303 Princess av., Camden  
Barnshaw, Harold D., 23 W. Cedar st., Merchantville  
Barroway, James N., 3064 Federal st., Camden  
Becker, C. Frederick, 620 Benson st., Camden  
Beideman, Casper M., 5 W. Maple av., Merchantv'le  
Bentley, David F., Jr., 406 Cooper st., Camden  
Betancourt, Raul R., 406 Cooper st., Camden  
Braun, William, 4307 W. Maple av., Merchantville  
Brennan, Charles L. S., 14 S. Broadway, Gloucester  
Brennan, John P., 429 Cooper st., Camden  
Brown, Stanley L., Glen av., Laurel Springs  
Browning, Wm. J., 134 N. Centre st., Merchantville  
Burns, Wilmer F., 267 White Horse Pk., Audubon  
Bush, Ralph K., 131 E. Park av., Merchantville  
Buzby, B. Franklin, 414 Cooper st., Camden  
Canuso, Nicholas A., 1528 Wildwood av., Camden  
Carlander, O. R., 1972 Browning rd., Merchantville  
Casselman, Arthur J., 301 N. Second st., Camden  
Chesnick, Reuben B., 135 W'dland ter., Oaklyn Manor  
Ciliberti, Frank J., Jr., 5th & Pine sts., Camden  
Clark, Ernest W., 407 Cooper st., Camden  
Cohen, Paul, 500 State st., Camden  
Collier, Martin H., Camden Co. T.B. Hosp., Lakeland  
Cooper, Robert A., 4307 Maple av., Merchantville  
Coxson, Harold P., Laurel rd., Stratford  
Crist, Walter A., 725 Collings av., W. Collingswood  
Cunningham, Joel B., 801 Cooper st., Camden  
Davis, Albert B., 511 Cooper st., Camden

Davis, J. Stannard, 350 Kings H'way E., Haddonfield  
Day, Grafton E., Frazer & N. J. avs., Collingswood  
Decker, Henry B., 527 Penn st., Camden  
Deibert, Irvin E., 538 Cooper st., Camden  
Deibert, Kirk R., 159 Elm av., Woodlynne  
Del Duca, Vincent P., 514 Cooper st., Camden  
Dempsey, J. Harvey, Washington av., Berlin  
Denbo, Elie A., Stark Gen. Hosp., Charleston, S. C.  
Driscoll, Chas. D., White H.Pk. & Grant av., W.C.'gsw'd  
Drossner, Jacob L., 1300 Park Blvd., Camden  
Ebner, Paul G., 719 Cooper st., Camden  
Ellis, Alexander, 513 Broadway, Camden  
Ewing, Leslie H., 10 Broad st., Berlin  
Eynon, Harold K., 579 Haddon av., Collingswood  
Eynon, James R., 700 Haddon av., Collingswood  
Farrell, Edgar A., 100 Kings Highway W., Haddonf'd  
Fessman, John W., Clements Bridge rd., Runnemede  
Gamon, Robert S., 514 Cooper st., Camden  
Geissler, Elmer E., 327 Monmouth st., Gloucester  
German, Geo. B., 429 Cooper st., Camden  
Gilbert, Phillip D., Cooper Hospital, Camden  
Glover, Lawrence L., 53 Kings H'way, W., Haddonf'd  
Goldman, Samuel, Seventh & State sts., Camden  
Goldstein, Hyman I., 1425 Broadway, Camden  
Gordon, Milton H., 12 N. 27th st., Camden  
Grenhart, Geo. W., 430 Haddon av., Camden  
Griffey, Wm. C., 132 Haddon av., Westmont  
Griscom, Lee E., 604 Broadway, Camden  
Hadley, C. Frazer, 210 W. Maple av., Merchantville  
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont  
Haines, Mabel C. S., 600 White Horse Pk., Audubon  
Hallinger, Earl S., 517 Cooper st., Camden  
Hanson, Alfred S., 533 Monmouth st., Gloucester  
Haury, Victor G., 206 Cedarcroft av., Audubon

Hemphill, E. H., 232 Kings Highway, E., Haddonfield  
 Hessert, Edmund C., 417 Cooper st., Camden  
 Hirst, E. Reed, 634 Federal st., Camden  
 Hollinshead, Beulah S., 600 Benson st., Camden  
 Howard, J. Edgar, 67 King's H'way, W., Haddonfield  
 Hughes, Thomas E., 223 Cooper st., Camden  
 Hummel, Ernest G., 414 Cooper st., Camden  
 Hummel, Merwin L., 135 N. Centre st., Merchantville  
 Husted, Gerald W., 306 Eighth av., Haddon Heights  
 Ironside, Paul A., 571 Benson st., Camden  
 Jack, H. Wesley, 533 Cooper st., Camden  
 Jackson, Chas. H., 1250 Park Blvd., Camden  
 Johnson, Herbert F., Cooper Hospital, Camden  
 Jones, John C., 805 Princeton av., Camden  
 Judson, G. Vernon, Jr., 1213 Clements Br. rd., Barr'gt'n  
 Kain, Thomas M., 403 Cooper st., Camden  
 Kerdasha, Richard F., 533 Cooper st., Camden  
 Keyser, David, 1518 Baird av., Camden  
 Kinney, Albert G., 917 Haddon av., Collingswood  
 Kline, Oram R., 414 Cooper st., Camden  
 Kutner, Chas., 1005 S. Fifth st., Camden  
 Lee, Benjamin F., Cooper Hospital, Camden  
 Lee, Thomas B., 622 Cooper st., Camden  
 Lewis, Thomas K., 47 S. 27th st., Camden  
 Lipsitz, Leopold S., 1404 Baird av., Camden  
 Lovett, Joseph C., Municipal Hospital, Camden  
 Lyon, Leslie C., P. O. Box 63, Magnolia  
 MacAlpine, Kenneth B., 308 Monm'th st., Gloucester  
 Madden, Theophilus W., 16 Frazer av., Collingsw'd  
 Magee, Edward S., 604 White Horse Pike, Oaklyn  
 Magee, Russell S., 201 White Horse Pike, Audubon  
 Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield  
 Maldeis, Albertos M. K., 117 N. Sixth st., Camden  
 Marcarian, Henry G., 917 Cooper st., Camden  
 Marcy, John W., 117 E. Park av., Merchantville  
 McCarthy, Arthur M., 2772 Federal st., Camden  
 McConaghy, Thomas P., 10th & Cooper sts., Camden  
 McDermott, Vincent T., 511 State st., Camden  
 McGlade, Thomas H., 2953 Yorkship Sq., Camden  
 Mecray, Paul M., 405 Cooper st., Camden  
 Mecray, Paul, Jr., 405 Cooper st., Camden  
 Mengel, Willard G., 400 Penn st., Camden  
 Meyer, George P., 410 Haddon av., Camden  
 Murray, Robert A., 27 East Greenwood av., Oaklyn  
 Ondovchak, M. Frederic, King's H'way, Mt. Ephraim  
 Ornaf, I. Edward, 1145 Thurman st., Camden  
 Osborn, Edward G., 509 State st., Camden  
 Osmun, Milton M., 133 Washington ter., Audubon  
 Phillips, Claude B., 891 Haddon av., Collingswood  
 Pike, Charles E., 4 E. Haddon av., Oaklyn  
 Pratt, Arthur G., 516 Cooper st., Camden  
 Pratt, William H., 516 Cooper st., Camden  
 Price, Henry S., Jr., 3005 Kearsage road, Camden  
 Principato, Roberto, 402 Walnut st., Camden  
 Rapp, Robert F., 932 Haddon av., Collingswood  
 Read, William T., Jr., Cooper Hospital, Camden  
 Rhone, David S., 1202 Haddon av., Camden  
 Richardson, Emma M., 581 Stevens st., Camden  
 Riegert, Louis C., 475 White Horse Pike, Collingsw'd  
 Ristine, Edwin R., 542 Cooper st., Camden  
 Roberts, Joseph E., Jr., 403 Cooper st., Camden  
 Rudolph, John P., 108 W. Maple av., Merchantville  
 Russell, Karl S., 219 New Jersey av., Collingswood  
 Ruttenberg, Max, 303 Cooper st., Camden  
 Samter, Max, 4711 Westfield av., Camden  
 Saunders, Orris W., 1700 Broadway, Camden  
 Schall, Reuben E., 537 N. Seventh st., Camden  
 Scheffler, Wilhelm A. H., 511 Cooper st., Camden  
 Schellenger, Edward A. Y., 429 Cooper st., Camden  
 Schrack, Helen F., 216 N. Fifth st., Camden  
 Schwartz, Henry C., Raritan av., Atco  
 Seto, Stanford P. T., Black Horse Pike, Blackwood  
 Shaen, Edward, 1229th Reception Center, Fort Dix  
 Shafer, Albert H., 405 Cooper st., Camden  
 Shafer, F. William, 634 Penn st., Camden  
 Sharp, Reuben L., 719 Cooper st., Camden  
 Shaw, Ernest B., 811 Collings av., W. Collingswood  
 Sheaffer, Clinton P., 241 King's Hghwy., E., Haddonfield  
 Shemeley, Wm. G., Jr., 7 Haddon av., Camden  
 Sherk, A. Lincoln, 2647 Westfield av., Camden  
 Shipman, James S., 514 Cooper st., Camden  
 Shope, Edward P., 511 Cooper st., Camden  
 Shull, Elliott C., 517 Cooper st., Camden  
 Sieber, Isaac G., 204 Merchant st., Audubon  
 Smith, Bertram H., 1000 Kings H'way, Haddon Hts.  
 Smith, James D., 701 N. Sixth st., Camden  
 Smith, Wilbur A., 2 E. Clinton av., Oaklyn  
 Smuda, Alphonse C., Glendora, Chews P. O.  
 Snagg, William T., 719 Cooper st., Camden  
 Sochacki, Alexander, 1478 Mt. Ephraim av., Camden  
 Stein, Joseph M., 457 Cooper st., Camden  
 Stephenson, Daniel H., 2704 Westfield av., Camden  
 Stone, Arthur L., 2838 Berkley st., Camden  
 Stone, Frank P., Laurel rd., Laurel Springs  
 Sufrin, Emanuel, 119 N. 27th st., Camden  
 Summerill, Garnett, 330 Cooper st., Camden  
 Swiecicki, Martin E., 317 Clements Br. rd., Barr'gt'n  
 Tatem, Henry R., Jr., Pine st. & Atlantic av., Audubon  
 Thompson, Penrose H., 4612 Westfield av., Camden  
 Traganza, Robt. W., 1576 Mt. Ephraim av., Camden  
 Van Sciver, John E. L., 64 Linden av., Haddonfield  
 Warwick, Ralph A., 3300 Federal st., Camden  
 Watkins, George R., La Pierre rd., Magnolia  
 Waugh, Bascom S., 1882 S. Tenth st., Camden  
 Weimann, Max L., 803 Station av., Haddon Heights  
 West, David H., 517 Cooper st., Camden  
 West, Gordon F., 527 Penn st., Camden  
 Wiant, Herman E., 100 Windsor av., Haddonfield  
 Wilson, Lester R., 3320 Federal st., Camden  
 Winter, Carl M., 3049 Constitution rd., Camden  
 Wright, Ralph S., 423 Richie av., W. Collingswood  
 Wroblewski, Benj. M., 1166 Thurman st., Camden

Number of Active Members and basis of representation, 180.

#### Honorary Members

Day, Grafton E., Collingswood  
 Lyon, Leslie C., Magnolia

Marcy, John W., Merchantville  
 Osmun, Milton M., Audubon

## CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on second Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

### Active Members

Bernheisel, Louis E., Reading av., Tuckahoe	Hughes, Frank R., Columbia av. & Oc'n st., Cape M'y
Brooks, George M., Cape May Court House	Hughes, Samuel B., Pine & Pacific avs., Wildwood
Cameron, C. Paul, 401 Atlantic av., Ocean City	Mace, Margaret, 2410 Atlantic av., N. Wildwood
Cohen, Maurice B., Pine & Pacific avs., Wildwood	Monasson-Friedland, Ida, Woodbine
Cooper, Jules, Washington st., Woodbine	Moon, Alexander C., Cape May
Corson, Allen, 824 Wesley av., Ocean City	Pettit, Herschel, 807 Wesley av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City	Robbins, Warren D., 202 Ocean av., Cape May
Cryder, Millard C., Cape May Court House	Smith, Marcia V., 821 Wesley av., Ocean City
Dandois, George F., 220 E. Wildwood av., Wildwood	Steel, William A., Beesley's Point
Friedland, Arnold J., Woodbine	Stuart, Alexander A. S., 4614 Landis av., Sea Isle City
Haines, F. B. Lane, 503 Ninth st., Ocean City	Townsend, John B., 824 Wesley av., Ocean City
Haines, Willits P., 601 Ninth st., Ocean City	Way, Clarence W., Office of Post Surg., Ft. Tilden, N.Y.
Hornstine, Harry H., 4015 Pacific av., Wildwood	Whiticar, John H., 717 Wesley av., Ocean City

Number of Active Members and basis of representation, 26.

### Honorary Members

Diverty, Henry B., Woodbury	Ulmer, Chester I., Gibbstown
Sewall, Millard F., Bridgeton	Wilkes, LeRoy A., Trenton

## CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

### Active Members

Aitken, Frank J., 119 N. Pearl st., Bridgeton	Mayhew, Charles H., 329 Pine st., Millville
Bacon, Mary, 278 E. Commerce st., Bridgeton	Mezzetti, Alfred F., 220 S. Sixth st., Vineland
Baker, Hugh W., 8th & Elmer sts., Vineland	Miller, H. Garrett, 203 E. Main st., Millville
Bauman, Kenneth R., 213 N. Third av., Millville	Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Bellak, Ellis R., Leesburg	Neal, Charles B., Pine & Third sts., Millville
Bennett, Samuel D., 118 Pine st., Millville	Nitshe, George A., Jr., 110 S. Main st., Elmer
Berkowitz, Benjamin, 188 E. Commerce st., Bridgeton	Pino, Anthony, 52nd Med. Bn., No. 301, Ft. Jackson, S.C.
Bostwick, Delazon S., Cumberland Hotel, Bridgeton	Ramsey, F. Muriel, 310 E. Pine st., Millville
Brantin, Howard S., 200 W. Main st., Millville	Reeves, J. Franklin, 55 East av., Bridgeton
Butcher, Charles, Heislerville	Rosen, Sol, 214 N. Second st., Millville
Cornwell, Alfred, 265 N. Laurel st., Bridgeton	Rosenthal, Bernice D., E. Landis av., Vineland
Corson, Kenneth E., 157th F. A., Fort Dix	Schwartz, Leon J., 114th Inf., No. 44, Ft. Bragg, N.C.
Cunningham, Chas., Jr., 165 F. A., No. 44, Ft. Bragg, N.C.	Scott, Leonard G., 21 Elm st., Bridgeton
Davies, George A., 53 Front st., Elmer	Sewall, Millard F., 195 E. Commerce st., Bridgeton
Day, Samuel T., Main st., Port Norris	Sharp, Charles E., Main st., Port Norris
DeSantis, Orazio J., 100 N. Second st., Millville	Sheppard, A. G., 309 Broad st., Elmer
Garrison, W. Sherman, Main st., Cedarville	Sheppard, Frank R., 131 N. Third st., Millville
Giacalone, Vincent, East Landis av., Vineland	Sheppard, Muse A., 102 Main st., Elmer
Gray, Charles M., 6th & Grape sts., Vineland	Sheppard, Thomas S., 21 E. Vine st., Millville
Greene, Edwin C., 61 N. Pearl st., Bridgeton	Shirlock, Margaret E., Training School, Vineland
Gricco, Anthony L., 830 Elmer st., Vineland	Siegel, Sidney L., 227 N. Second st., Millville
Jonas, August, 328 E. Broadway, Salem	Thalheimer, Edward J., 7th & Plum sts., Vineland
Kauffmann, Louis J., 228 N. Second st., Millville	Thomas, George N., 712 Wood st., Vineland
Knowles, James S., 318 N. Second st., Millville	Walker, Ada H., 635 Landis av., Vineland
Kratka, William H., 123 N. Pearl st., Bridgeton	Walker, H. Burton, 635 Landis av., Vineland
Kump, Albert B., 31 W. Commerce st., Bridgeton	Ware, Carl N., Bridgeton rd., Shiloh
Lihn, Barney, Hdq. Olmsted Field, Middletown, Pa.	Weithaase, Helen E., 8th & Elmer sts., Vineland
Lore, Harry E., Main st., Cedarville	Whaland, Berta, 117 Atlantic st., Bridgeton
Lyon, Earl C., 194 E. Commerce st., Bridgeton	Wilson, Charles W., 636 Wood st., Vineland
Magolda, Anthony F., 727 Grape st., Vineland	Wilson, Herbert H., 24 Bank st., Bridgeton
Marchione, Nicholas E., 109 S. Seventh st., Vineland	Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 630 Landis av., Vineland	

Number of Active Members and basis of representation, 63.

### Honorary Members

Elmer, Matthew K., Bridgeton	Simpkins, Raymond, Bridgeton
Harris, Allan, Greenwich	Wainwright, Frederick P., Bridgeton



## ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

## Active Members

- Abel, Arthur R., 144 Harrison st., East Orange  
 Abrams, Abram B., 299 Clinton av., Newark  
 Adelman, Benjamin B., 190 Clinton av., Newark  
 Agnew, Hobart M., 17 Plymouth st., Montclair  
 Albano, Edwin H., 144 Harrison st., East Orange  
 Albano, Frank J., 535 North 7th st., Newark  
 Albano, Joseph, 535 North 7th st., Newark  
 Alcamo, John H., 215 Littleton av., Newark  
 Alexander, Walter G., 48 Webster pl., Orange  
 Alford, Ralph I., 83 Park st., Montclair  
 Allan, James S., 144 Harrison st., East Orange  
 Allen, Chester B., Jr., 254 Midland av., Montclair  
 Allen, G. Herbert, 181 Roseville av., Newark  
 Alling, Frederic A., 15 Washington st., Newark  
 Altman, Charles D., 301 Highland av., Newark  
 Ambrose, Anthony, 71 Congress st., Newark  
 Anderson, William A., 1255 Broad st., Bloomfield  
 Angelillo, Marc C., 169 Bloomfield av., Newark  
 Antonius, Nicholas A., 27 W. Market st., Newark  
 Anuario, Charles B., 365 S. Centre st., Orange  
 Applebaum, Irving L., 31 Lincoln Park, Newark  
 Areson, Wm. H., 153 Bellevue av., Upper Montclair  
 Arons, Harry, 6 Milford av., Newark  
 Ash, Samuel, 866 So. 13th st., Newark  
 Asher, Maurice, 186 Clinton av., Newark  
 Aszody, Paul, 340 Waverly av., Newark  
 Bachmann, Wm., 87 Hillcrest ter., East Orange  
 Bacote, Ernest F., 78 Barclay st., Newark  
 Bagg, Linus W., 31 Lincoln Park, Newark  
 Baiocchi, Pascal J., 203 Hunterdon st., Newark  
 Baird, Thompson M., 168 Magnolia av., Arlington  
 Baker, Charles F., 198 Clinton av., Newark  
 Baker, Maclyn F., 987 Sanford av., Irvington  
 Baldwin, Samuel H., 626 Clinton av., Newark  
 Barbello, Joseph D., 498 N. 13th st., Newark  
 Barkhorn, Charles W., 223 Roseville av., Newark  
 Barkhorn, Henry C., 45 Johnson av., Newark  
 Barnard, Frank G., 22 Plymouth st., Montclair  
 Barrett, John E., 635 Summer av., Newark  
 Barrett, Joseph F., 230 Parker av., Maplewood  
 Bass, Rose D., 54 Lyons av., Newark  
 Baum, Felix, 10 Elm court, South Orange  
 Baum, Samuel, 10 Osborne ter., Newark  
 Bauman, Everett O., 17 Hillside av., Newark  
 Bauman, Rush C., 92 High st., Nutley  
 Becker, Frederick W., 14 Clinton pl., Newark  
 Becker, Martin, 94 So. Munn av., East Orange  
 Becket, George C., 350 Springdale av., East Orange  
 Beling, C. Abbott, 111 Clinton av., Newark  
 Beling, Christopher C., 111 Clinton av., Newark  
 Bell, Horace O., Essex Co. Isolation Hosp., Belleville  
 Bell, Thomas, 340 Belmont av., Newark  
 Benedict, Alfred C., 121 Irvington av., South Orange  
 Bengelsdorf, Aron, 29 Clinton pl., Newark  
 Bennett, Wm. F., Essex Mt. Sanatorium, Verona  
 Berardinelli, Carmine G., 92 Eighth av., Newark  
 Berg, Samuel, 156 Roseville av., Newark  
 Berger, Wm. A., 346 Roseville av., Newark  
 Bergman, Meyer W., 31 Lincoln Park, Newark  
 Berman, H. Robert, 299 Clinton av., Newark  
 Bernhard, Wm. G., 142 Clinton av., Newark  
 Bernstein, Arthur, 668 Clinton av., Newark  
 Bernstein, Julius, 584 S. 10th st., Newark  
 Besson, Franklin J., 999 Clinton av., Irvington  
 Beyer, Othmar J., 42 Laurel av., Irvington  
 Bianchi, Angelo R., 184 Hunterdon st., Newark  
 Bien, Frank A., 999 Clinton av., Irvington  
 Bigelow, Elizabeth F., 120 Prospect st., So. Orange  
 Bigelow, Nelson S., 120 Prospect st., South Orange  
 Bingham, Arthur W., 144 Harrison st., East Orange  
 Birdsall, Clarence A., 9 Smull av., Caldwell  
 Bissett, John V., 29 Hawthorne av., East Orange  
 Biunno, Anthony J., Station Hosp. 2, Ft. Bragg, N.C.  
 Blaustein, Maurice L., 37 Hillside av., Newark  
 Bleiberg, Jacob, 31 Lincoln Park, Newark  
 Block, Marcus T., 177 Bloomfield av., Newark  
 Block, Max, 48 N. Fullerton av., Montclair  
 Block, Milton, 342 Union av., Irvington  
 Bocchini, Joseph A., 366 S. 12th st., Newark  
 Bolten, Bernard, Station Hosp., Camp Claiborne, La.  
 Bonomo, Michael J., 587 S. 10th st., Newark  
 Borsher, Irving P., 249 Broad st., Bloomfield  
 Bove, Joseph, 306 Lincoln av., Orange  
 Brackett, Elizabeth R., 371 Franklin av., Nutley  
 Bradford, Stella S., 16 Seymour st., Montclair  
 Bradshaw, John H., 27 High st., Orange  
 Brakeley, Elizabeth, 71 Myrtle av., Montclair  
 Brandman, Otto, 83 Johnson av., Newark  
 Braun, Gustav A., 221 S. Orange av., Newark  
 Breitstadt, Charles A., 157 Elwood av., Newark  
 Brien, William M., 449 Main st., Orange  
 Briggs, Henry, 144 Harrison st., East Orange  
 Brim, Anne S., 179 So. Harrison st., East Orange  
 Broadnax, Mary E., 140 Roseville av., Newark  
 Brodtkin, Eva T., 365 Osborne ter., Newark  
 Brodtkin, Henry A., Tilton Hospital, Fort Dix  
 Brodtkin, Louis A., 872 Chancellor av., Irvington  
 Brotman, Morton M., 90 Avon av., Newark  
 Brown, Chester R., 22 Midland av., Arlington  
 Brown, Chester T., Prudential Ins. Co., Newark  
 Brown, Harold W., 27 S. Fullerton av., Montclair  
 Brown, Lewis W., 160 Roseville av., Newark  
 Bruning, Richard H., 372 Wyoming av., Maplewood  
 Buckley, Jeremiah L., 666 Franklin av., Nutley  
 Bull, Louis M., 92 Heller Parkway, Newark  
 Bull, Robert I., 361 Lafayette st., Newark  
 Bull, William J., 98 Park st., Montclair  
 Burke, Leonard P., 39 Lakeside av., Verona  
 Burke, Stephen E., 212 First av., Newark  
 Burne, John J., 17 Gould av., Newark  
 Burbeau, Wm. P., Walter Reed Hosp., Wash'g't'n, D.C.  
 Burrill, Benjamin B., Jr., 303 Montgomery st., Bl'm'f'd  
 Burrus, Thomas P., 24 E. Park st., Newark  
 Burstein, Frank, 72 Osborne ter., Newark  
 Busch, Herman, 33 Johnson av., Newark  
 Bush, Archer C., 40 Union st., Montclair  
 Butan, Louis, 579 Valley rd., W. Orange  
 Butler, Eustace C., 249 Bloomfield av., Caldwell  
 Buvinger, Chas. W., 50 Washington st., East Orange  
 Byck, Louis, 794 South 11th st., Newark  
 Byrnes, Elizabeth W., 901 Spaight st., Madison, Wis.  
 Bythewood, Alton E., Jr., 145 W. Market st., Newark  
 Cacciarelli, Robert A., 517 Roseville av., Newark  
 Caggiano, Anthony P., 237 Grove st., Montclair  
 Cahill, Laurence A., 361 Lafayette st., Newark  
 Caldwell, Donald M., 111 Harrison st., East Orange  
 Calvert, Wm. C., 225 Gregory av., West Orange  
 Camche, Leo J., 250 Renner av., Newark  
 Cameron, Arthur E., 59 Somerset st., Newark  
 Cameron, Edwin A., 186 S. Burnett st., East Orange  
 Campbell, Wm., 144 Harrison st., East Orange  
 Cantalupo, Emidio, 95 Nichols st., Newark  
 Caputo, Anthony R., 151 Washington av., Belleville  
 Carbone, Francesco N., 440 Central av., Orange  
 Cardwell, Edgar P., 47 Central av., Newark  
 Carlisle, Paul E., 763 Broad st., Newark

- Carman, Fletcher F., 21 Parkway, Montclair  
Carpenter, Charles A., 30 Francis pl., Caldwell  
Carrigan, Francis P., 305 Roseville av., Newark  
Carrol, Wilfred, 51 Ingraham pl., Newark  
Casale, John B., 359 Bloomfield av., Newark  
Castellano, Martin G., Essex Mountain Sana., Verona  
Cater, Douglas A., 57 So. Harrison st., East Orange  
Cerone, Daniel M., 309 First av., Newark  
Cestone, Canio, 521 Pompton av., Cedar Grove  
Chamberlain, Aims R., 30 Lenox pl., Maplewood  
Chamberlain, Richard R., 30 Lenox pl., Maplewood  
Champlin, Paul M., 43 S. Arlington av., E. Orange  
Chapman, Robt. W., WardHmstd., Boyden av., Mplwd.  
Chernus, Jack, 119th Med. Reg., 44th Div., Fort Dix  
Chiger, Alexander S., 621 High st., Newark  
Chimacoff, Hyman, 171 Elizabeth av., Newark  
Chmelnik, Abraham G., 299 Clinton av., Newark  
Christian, Albion C., 1080 Clinton av., Irvington  
Christoph, Francis T., Station Hosp., Cp. Claiborne, La.  
Clark, J. Henry, 108 Orange rd., Montclair  
Clarke, Jos. A., 30 Van Ness pl., Newark  
Claus, C. Hermann, 776 S. 19th st., Newark  
Clement, Baxter L., 15 Washington st., Newark  
Coe, Richard, 156 Clinton av., Newark  
Coffey, Michael J., 24 W. Market st., Newark  
Coffin, Henry F., 116 N. Ninth st., Newark  
Coghlan, Jasper, 540 Parker st., Newark  
Cohen, I. Elvin, 561 Elizabeth av., Newark  
Cohen, Maurice, 106 Valley rd., Montclair  
Cohen, Max, 60 Ridge rd., North Arlington  
Cohen, Meyer J., 118 Johnson av., Newark  
Cohen, Sidney A., 283 Clinton pl., Newark  
Cohen, Sidney L., 20 Avon av., Newark  
Cohen, Sidney P., 1209th Station Hosp., Pine Cp., N.Y.  
Cohn, Hermann, 393 Clinton av., Newark  
Cohn, Roy M., 740 Clinton av., Newark  
Coleman, Russell M., 54 N. Clinton st., East Orange  
Colmer, M. Jonas, 31 Lincoln Park, Newark  
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood  
Colton, Ethan T., Jr., 31 Park st., Montclair  
Comando, Harry N., 690 Clinton av., Newark  
Connamacher, Harold S., 671 Springfield av., New'rK  
Connolly, John J., 180 Ballantine Pkwy., Newark  
Connolly, Richard N., 117 Fifth st., Newark  
Conti, Horace, 229 Kearny av., Kearny  
Cook, Hugh F., 21 Roseville av., Newark  
Cooke, William H., 303 Main st., East Orange  
Cooperman, William, 647 Market st., Newark  
Cornish, Charles H., 673 Prospect st., Maplewood  
Coughlan, Ella A., 10 Oakwood av., Orange  
Coughlin, Frank J., 100 Magnolia av., Arlington  
Cox, John C., 55 Woodland rd., Maplewood  
Cox, William W., 79 S. Fullerton av., Montclair  
Crane, Charles G., 78 Farley av., Newark  
Craster, Charles V., Plane & William sts., Newark  
Crawford, Georgina U., 28 Carnegie av., E. Orange  
Crecca, Anthony D., 76 Second st., Newark  
Crecca, William D., 111 Park av., Newark  
Cregar, John S., 150 Harrison st., East Orange  
Crossfield, Henry C., 144 Harrison st., East Orange  
Crystell, Edward H., 4 Hawthorne av., Nutley  
Curtis, Elbert A., 65 Central av., Newark  
D'Addario, Anthony R., 118 F.A. 2Bn., Ft. Jacks'n S.C.  
D'Agostini, Robert J., 304 W. Market st., Newark  
D'Alessandro, Arthur J., 15 Salem st., Newark  
D'Ambola, Philip R., 21 S. Sixth st., Harrison  
D'Amico, Thomas V., 16 Grove av., Verona  
Dane, Charles, 61 Scotland rd., South Orange  
Dane, John, 61 Scotland rd., South Orange  
D'Angelo, Joseph C., 330 Washington av., Belleville  
Danzis, Maximillian, 31 Lincoln Park, Newark  
Darden, Walter T., 149 W. Kinney st., Newark  
Daron, Simeon, 31 Lincoln Park, Newark  
Davidson, Henry A., Walter Reed Hosp., W'sh'gt'n, D.C.  
Davidson, Louis L., 31 Lincoln Park, Newark  
Davies, Geo. W., 35 Fairview av., Verona  
Davis, Louis, 825 S. Tenth st., Newark  
Davis, Thomas C., 30 Old Short Hills rd., Millburn  
DeFronzo, Morando, 180 Fairmount av., Newark  
DeGermone, James H., 10 Ridgewood av., Glen Ridge  
DeHart, George K., 132 Sunset av., Verona  
Del Deo, Nicholas V., 49 State st., Newark  
Del Guercio, Olindo, 365 Bloomfield av., Newark  
Del Negro, Albert E., Ordnance Depot, Savanna, Ill.  
DeMichele, Roland V., G. D., Montgomery, Ala.  
Denes, Oscar, 402 Centre st., Nutley  
DePalma, Anthony F., 533 Mt. Prospect av., Newark  
DePhillips, Benedict R., 43 Park av., Newark  
Dessauer, Joseph, 80 Clinton av., Newark  
DeTroia, Fred'k C., Station Hosp., Fort Jay, N. Y.  
Deutel, Oscar R., 283 Franklin st., Bloomfield  
De Vincentis, Henry, 285 Henry st., Orange  
Devlin, Hugh J., 72 Thomas st., Newark  
Dias, Joseph L., 17 Lombardy st., Newark  
Dieffenbach, Richard H., 570 Mt. Prospect av., New'k  
Diener, Sam'l, 760th Tank Bn., G.H.Q., C'p Bowie, Tex.  
DiFino, Felix J., 88 Jefferson st., Newark  
DiGiacomo, Harry E., 2 Prospect pl., Newark  
DiGiacomo, Wm. H., 223 Fairmount av., Newark  
Dinge, Ferdinand C., 67 S. Munn av., East Orange  
Dodd, Edward L., 157 Forest st., Belleville  
Donahue, William J., 71 S. Ninth st., Newark  
Donchi, Sol M., 9 Madison av., Newark  
Dorn, Elliott I., 267 Vassar av., Newark  
Dowd, Ambrose F., 239 Broadway, Newark  
Dragonetti, Elvige N., 177 Clifton av., Newark  
Dranow, Paul, 233 Franklin av., Nutley  
Drapkin, Berta, 31 Lincoln Park, Newark  
Dreskin, Jacob L., 172 Lyons av., Newark  
DuBois, Morris G., 769 High st., Newark  
Dulin, Everett V., 144 Harrison st., East Orange  
Dunn, Theodore B., 35 Park pl., Bloomfield  
Durchlag, E. Nelson, 12 Myrtle av., Irvington  
Eagleton, Wells P., 15 Lombardy st., Newark  
Ebenfeld, Samuel W., 344 High st., Newark  
Echikson, Joseph I., 31 Lincoln Park, Newark  
Edelen, James J., 280 So. Clinton st., East Orange  
Ehrlich, Edward, 79 Shanley av., Newark  
Ehrlich, William E., 31 Lincoln Park, Newark  
Eichler, Bernard B., 221 Midland av., Montclair  
Eigen, Louis A., 511 Valley rd., West Orange  
Ein, William B., 31 Lincoln Park, Newark  
Einhorn, Samuel E., 13th Coast Art., Ft. Barrancas, Fla.  
Eisenberg, David S., 31 Lincoln Park, Newark  
Ellis, Arthur J., 282 Broad st., Newark  
Emerson, Linn, 303 Park av., Orange  
Emmer, S. Wolfe, 31 Lincoln Park, Newark  
Englander, Charles, 41 Hillside av., Newark  
English, John T., 110 Yale av., Irvington  
Epler, Don A., 45 Hillside av., Newark  
Epstein, Harry B., 31 Lincoln Park, Newark  
Epstein, William M., 134th Med. Reg., Ft. Bragg, N.C.  
Erdman, George L., 142 Clinton av., Newark  
Erler, Eugene W., 360 Irving av., South Orange  
Ervin, Millard B., 572 Prospect st., Maplewood  
Etheridge, Chas. H., 433 Prospect st., East Orange  
Evans, Chas. H., 144 Harrison st., East Orange  
Evans, David P., 144 Harrison st., East Orange  
Ewing, Harvey M., 31 Trinity pl., Montclair  
Fader, Ferdinand, 3 So. Grove st., East Orange  
Fager, Rudolph O., 53 Park pl., Bloomfield  
Failing, Brayton E., 31 Lincoln Park, Newark  
Fanburg, Sol J., 31 Lincoln Park, Newark  
Farden, Joseph L., 342 Roseville av., Newark  
Farr, Irving L., 214 Walnut st., Montclair  
Fasano, Giovanni, 194 S. 7th st., Newark  
Faughnan, Rose C., 97 High st., Passaic  
Fava, Philip V., 355 Sanford av., Newark  
Fein, Bernard, 585 Elizabeth av., Newark  
Feinsod, Samuel N., 1305 Clinton av., Irvington



- Feldman, Frank H., 115 Lyons av., Newark  
 Fendrick, Edward, 17 Watson av., East Orange  
 Fenichel, Benj., 148th Inf. Med. Det., Cp. Shelby, Miss.  
 Ferguson, Wm. E., 22 James st., Newark  
 Fern, Samuel S., 122 Elizabeth av., Newark  
 Feuer, Joseph A., 654 Elm st., Arlington  
 Fewsmith, Joseph L., 120 Second av., Newark  
 Fine, M. James, 65 Girard pl., Newark  
 Fink, Irving E., 129 Lyons av., Newark  
 Finkel, Joshua, 368 Clinton av., Newark  
 Finkelstein, Abe S., 670 Clinton av., Newark  
 Finklestein, Herman, Med. Det., Arsenal, Huntsville, Ala.  
 Finkler, Rita S., 35 Leslie st., Newark  
 Finnerty, Urban R., 71 Park st., Montclair  
 Fischbein, Martin M., 817 Chancellor av., Irvington  
 Fischer, David D., 356 Millburn av., Millburn  
 Fischer, Edward J., 29 Ashwood ter., West Orange  
 Fischman, Harold H., 326 Avon av., Newark  
 Fitzpatrick, Edw. F., 546 W. Market st., Newark  
 Flanagan, John J., 173 Roseville av., Newark  
 Flax, Charles H., 1 Baldwin av., Newark  
 Fleischmann, Viola G., 341 16th av., Irvington  
 Fleming, Joseph A., 247 Claremont av., Montclair  
 Flower, Morrie A., 39 Lincoln Park, Newark  
 Flynn, Edward A., 176 Washington av., Belleville  
 Foley, James F., 331 N. Grove st., East Orange  
 Ford, Theodore R., 144 Harrison st., East Orange  
 Forsyth, Kenneth C., 8 Ziegler Tract, Carney's Point  
 Fort, J. Irving, 306 Roseville av., Newark  
 Forte, Daniel L., 545 Centre av., Orange  
 Forte, Frank S., 318 Roseville av., Newark  
 Fortunato, Samuel J., Station Hosp., Cp. Claiborne, La.  
 Fost, William H., 107 Franklin st., Belleville  
 Foster, Herbert W., 2 Erwin Park, Montclair  
 Fowler, Royale H., 744 Broad st., Newark  
 Frame, Dorothy L., 15 Highland av., Glen Ridge  
 Franklin, Frank A., 256 S. Central av., Orange  
 Fratantuno, Michael J., 78th F. A., Ft. Benning, Ga.  
 Freeman, George C., Prudential Ins. Co., Newark  
 Freeman, Richard D., 370 Central av., Orange  
 Freinkel, Jacob, 2 Hillside av., Newark  
 Friedman, Harry, 721 S. 16th st., Newark  
 Friedman, Hyman, 1096 Sanford av., Irvington  
 Friedman, Milton, 31 Lincoln Park, Newark  
 Friedrich, Adam H., 424 Lafayette st., Newark  
 Froelich, Joseph C., 74 Ingraham pl., Newark  
 Furman, Benj. A., 31 Roseville av., Newark  
 Furst, Nathan J., 299 Clinton av., Newark  
 Galoto, Frank M., 188 Ampere Pkwy., Bloomfield  
 Gamba, Joseph, 388 Fairmount av., Newark  
 Ganley, Arthur J., 390 Park av., East Orange  
 Ganot, Frank I., 392 Ridge st., Newark  
 Gardam, Joseph W., 16 Longfellow av., Newark  
 Gardner, Kenneth E., 45 Fremont st., Bloomfield  
 Gauch, William, 177 Elwood av., Newark  
 Gelb, Jerome, 84 W. Alpine st., Newark  
 Geller, Samuel, 696 High st., Newark  
 Gennell, Ernest, 298 Parker st., Newark  
 George, Melbourne E. W., 744 Broad st., Newark  
 Gerard, Patrick D., 364 Roseville av., Newark  
 Gershenfeld, David B., 20 Hillside av., Newark  
 Giannetti, Ernest D., 14 Harrison av., Montclair  
 Giardina, John S., 341 Walnut st., Newark  
 Gibbins, A. Leslie, 119 Fifth st., Newark  
 Gibson, Augustus, 86 Park st., Upper Montclair  
 Giffoniello, Arthur A., 200 Fairmount av., Newark  
 Gifford, William R., 247 Park av., East Orange  
 Gilligan, Walter W., 44th Inf. Div., Fort Dix  
 Gilman, Chas. M. B., 59 Seeley av., Arlington  
 Gilmour, John R., 144 S. Harrison st., East Orange  
 Gluffra, Frank, 161 Park st., Montclair  
 Glass, Oscar, 838 S. 12th st., Newark  
 Glass, Wm. H., 144 Harrison st., East Orange  
 Glazier, Jesse T., 670 Sanford av., Newark  
 Gluckman, Saul K., 78 Johnson av., Newark  
 Godfrey, Alan O., 231 Roseville av., Newark  
 Goeller, Jacob D., 1165 W. Clinton av., Irvington  
 Goffman, Emanuel, 316 Claremont av., Montclair  
 Goldberg, Harold H., 814 S. 10th st., Newark  
 Goldberg, Louis E., 31 Lincoln Park, Newark  
 Goldberg, Samuel A., 169 Gregory av., West Orange  
 Goldberg, Samuel M., 353 Washington av., Belleville  
 Golden, Clement H., 347 16th av., Irvington  
 Goldman, Jerome, 904 West Adam st., Chicago, Ill.  
 Goldman, Lester M., 53 Leslie st., Newark  
 Goldmann, Joseph, 103 N. Walnut st., East Orange  
 Goldstein, Henry Z., 31 Lincoln Park, Newark  
 Goldstein, Samuel M., 40 Johnson av., Newark  
 Goldstein, Wm. H., 632 Belgrove dr., Arlington  
 Goodfellow, Gordon P., 196 Prospect st., E. Orange  
 Gordon, A. Julius, 351 Roseville av., Newark  
 Grady, Wm. F., 42 N. Fullerton av., Montclair  
 Granberry, D. Webb, 136 S. Main st., Orange  
 Grant, William F., 309 Roseville av., Newark  
 Grasso, Anthony P., 243 Littleton av., Newark  
 Gray, John W., 142 Clinton av., Newark  
 Greenberg, Nathan H., Station Hosp., Cp. Forrest, Tenn.  
 Greenberg, Samuel, 46 Johnson av., Newark  
 Greenfield, Bernard H., 691 Clinton av., Newark  
 Greenfield, Leonard S., 691 Clinton av., Newark  
 Greenwald, Theo. L., 44 Maple av., Morristown  
 Greer, Melvin A., 190 Washington st., Bloomfield  
 Gregorius, Ralph F., 120 Irvington av., So. Orange  
 Gregory, Mildred G., 64 N. 9th st., Newark  
 Greifinger, William, 22 Vassar av., Newark  
 Greifinger, Marcus H., 200 Ferry st., Newark  
 Griffin, Guy B., 197 S. Centre st., Orange  
 Griffith, Roy, 909 Broad st., Newark  
 Gross, Isidore, 60 Lakeside av., Verona  
 Grossblatt, Philip, 67 Baldwin av., Newark  
 Grubin, Harold, 22 Treacy av., Newark  
 Gulick, James B., 144 S. Harrison st., East Orange  
 Gullord, Edw. G., 284 Bellevue av., Up. Montclair  
 Guthrie, Wilson G., 550 Parker st., Newark  
 Gutowski, Walter T., 104 Grove ter., Irvington  
 Hadley, Elinor E., 5 Mountain av., Maplewood  
 Hagen, Walter H., Stark Gen. Hosp., Charleston, S.C.  
 Hagman, Frank E., 82 Grand place, No. Arlington  
 Hahn, Katherine B., 372 Thornden st., South Orange  
 Hahn, William H., 15 Lombardy st., Newark  
 Haley, Paul W., 781 Sanford av., Newark  
 Halpern, Melvin M., 493 Central av., Newark  
 Halpern, William, Woodbine  
 Halprin, Harry, 8 Washburn pl., Caldwell  
 Halsey, Levi W., 61 Church st., Montclair  
 Hamilton, Robert G., 92 Main st., Orange  
 Hamley, John J., 296 Roseville av., Newark  
 Hanan, James T., 11 The Crescent, Montclair  
 Hantman, Harold, 196 Roseville av., Newark  
 Harden, Albert S., 510 W. Market st., Newark  
 Harden, Albert S., Jr., 551 Ridgewood rd., Maplewood  
 Harris, Morris, 102 Broad st., Bloomfield  
 Hartman, Winfield L., Jr., Carlisle Bar'ks, Carlisle, Pa.  
 Harvey, Robert K., 711 Kearny av., Arlington  
 Harvey, Thomas W., Jr., 59 Main st., Orange  
 Haschec, Walter, 690 S. 19th st., Newark  
 Haskin, Aaron H., 80 Millington av., Newark  
 Hatcher, George A., Essex Co. Hosp., Cedar Grove  
 Hauck, Lydia R. B., 644 Stuyvesant av., Irvington  
 Hauck, Wm. H., 644 Stuyvesant av., Irvington  
 Hawkes, E. Zeh, 84 Washington st., Newark  
 Hawkes, Stuart Z., 84 Washington st., Newark  
 Hayes, Gerald W., 86 Hawthorne av., East Orange  
 Heineken, Theodore S., 17 Park pl., Bloomfield  
 Heller, Abraham R., 494 Belgrove dr., Arlington  
 Heller, Nathan B., 31 Lincoln Park, Newark  
 Henle, Carye-Belle, 671 Springfield av., Newark  
 Hennig, Paul F., 688 Stuyvesant av., Irvington  
 Hermann, John H., 197 S. Centre st., Orange  
 Herndon, Lewis S., 144 S. Harrison st., East Orange



Herold, Harvey T., 850 S. 13th st., Newark  
Hewson, George F., 21 Roseville av., Newark  
Hexamer, Fred, 50 Lyons av., Newark  
Heyman, Arthur, 79 Baldwin av., Newark  
Hicks, Alfred M., 63 Park st., Montclair  
Hill, James O., 84 Barclay st., Newark  
Hill, Robert H., 339 Parker st., Newark  
Hirschberg, Samuel, 615 High st., Newark  
Hobart, Richard T., 454 Park st., Upper Montclair  
Holler, Henry G., 234 Montclair av., Newark  
Holmes, George J., 17 Elizabeth av., Newark  
Holtz, Harry M., 299 Clinton av., Newark  
Hooton, Thomas C., 31 Trinity pl., Montclair  
Horland, Aaron H., Station Hosp., Newark Airport  
Horn, Harry, 622 Stuyvesant av., Irvington  
Horn, Max, 850 South 11th st., Newark  
Horsford, Frederick C., 305 Broadway, Newark  
Hosp, Paul H., 842 S. 12th st., Newark  
Howell, Thomas W., 102nd Cav., Ft. Jackson, S. C.  
Hubach, Maximilian F., Jr., 307 Montg'm'y st., Bl'mf'd  
Hubbard, Fayette E., 65 Church st., Montclair  
Hubbard, Robert Y., 942 Sanford av., Irvington  
Huber, Wm. H., 587 Prospect st., Maplewood  
Huberman, John, 853 S. 12th st., Newark  
Hughes, Lee W., 965 Broad st., Newark  
Hulett, Albert G., 612 M'Clellan av., Ft. Le've'nw'th, Kan.  
Humphries, Robert E., 637 Central av., East Orange  
Hurff, J. Wallace, 86 Washington st., Newark  
Husserl, Siegfried, 777 Clinton av., Newark  
Hymowitz, Ben, 66 Baldwin av., Newark  
Ill, Carl H., 188 Clinton av., Newark  
Ill, Edmund W., 188 Clinton av., Newark  
Ill, Edward J., 88 Treacy av., Newark  
Ill, Herbert M., 188 Clinton av., Newark  
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 Pannullo, John N. P., 266 Van Buren st., Newark  
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 Toczek, Heinrich A., 404 Bergen st., Newark  
 Tomec, Richard F., 42 Melrose pl., Montclair  
 Torppey, John J., 472 Sanford av., Newark  
 Toye, John E., 90 Midland av., Arlington  
 Trautwein, Charles F., 131 Nesbit ter., Irvington  
 Turi, Amedeo E., 57 Garside st., Newark  
 Turner, Charles F., 151 Grove st., Montclair  
 Tushnet, Leonard, 662 18th av., Irvington  
 Tutela, Arthur C., 220 S. 7th st., Newark  
 Tutschulte, Ernest, 111 Mt. Pleasant av., Newark  
 Twitchell, Adelbert B., 162 S. Orange av., S. Orange  
 Tymeson, Walter R., 310 Main st., Orange  
 Ulan, Oscar, 170 Fleming av., Newark  
 Ulvestad, Lawrence E., 147 Halsted st., E. Orange  
 Urbach, George, 181 Chancellor av., Newark  
 Valentin, Irmgard, 131 S. Harrison st., East Orange  
 Vallario, Frank A., 333 Clifton av., Newark  
 Vander Veer, H. Garrett, 295 Montgomery st., Bl'mf'd  
 Van Emburgh, Geo. H., 575 Belgrove dr., Arlington  
 Van Gieson, Edward J., 70 Watessing av., Bloomf'd  
 Vannatta, Geo. W., 226 N. Park st., East Orange  
 Van Ness, H. Roy, 444 Parker st., Newark  
 Verbeck, George B., 20 Church av., BallstonSpa, N.Y.  
 Vincent, Nicholas F., 144 S. Harrison st., E. Orange  
 Virgilio, Anthony A., 87 S. Centre st., Orange  
 VonHofe, Frederick H., 75 Prospect st., E. Orange  
 Voorhees, Florence E., 140 Roseville av., Newark  
 Vreeland, Ralph D., 400 Highland ter., Orange  
 Wakeley, Wm. E., 144 Harrison st., East Orange  
 Waldron, Robert E., 1194 Broad st., Bloomfield  
 Wallhauser, Henry J. F., Hotel Belvidere, Belvidere  
 Walsh, Charles R., 21 W. Mt. Pleasant av., Liv'g'st'n  
 Walton, Ralph W., 102 Gates av., Montclair  
 Wangner, William F., 1 Willard av., Bloomfield  
 Ward, Elisabeth B., 112 Chancellor av., Newark  
 Ward, Gertrude P., 41 Park pl., Bloomfield  
 Ward, William R., 112 Chancellor av., Newark  
 Ward, William R., Jr., 112 Chancellor av., Newark  
 Warner, Wm. H. A., 444 Central av., East Orange  
 Waterman, Samuel M., 364 Clinton av., Newark  
 Weber, Francis C., 286 Mt. Prospect av., Newark  
 Weeks, Norman E., 470 Grove st., Up. Montclair  
 Weinberg, Alfred, 654 Lyons av., Irvington  
 Weinmann, Max. H., 714 Scotland rd., Orange  
 Weinstein, Francis S., 189 16th av., Newark  
 Weinstein, Morris W., 604 Chancellor av., Irvington  
 Weiss, Louis, 519 Springfield av., Newark  
 Weiss, Selma, 2 Stratford pl., Newark  
 Welkind, Allen A., 299 Clinton av., Newark  
 Weller, Arthur, 19 Hillyer st., Orange  
 Weston, Clifford G., 27 Woodland av., Glen Ridge  
 Wheeler, Wm. K., 31 Lincoln Park, Newark  
 Whelan, Edward P., 460 Franklin av., Nutley  
 Wherry, Elmer G., 325 Clinton av., Newark  
 White, Robert R., 144 S. Harrison st., East Orange  
 Wiener, David, 196 Weequahic av., Newark  
 Willan, Edward H., 74 S. Munn av., East Orange  
 Willey, F. Parker, 153 Roseville av., Newark  
 Williams, John J., 88 Walnut st., Newark  
 Willis, Katharen C., 31 Trinity pl., Montclair  
 Willner, Irving, 18 Waverly av., Newark  
 Willner, Philip, 852 S. 11th st., Newark  
 Willson, James H., 144 Harrison st., East Orange  
 Wilson, John H., Jr., 85 Halsted st., East Orange  
 Wolf, Raymond E., 251 Ridgewood av., Glen Ridge  
 Wolfe, Jacob S., 44 Watessing av., Bloomfield  
 Wolfe, William W., 383 Mulberry st., Newark  
 Wood, E. LeRoy, 160 Roseville av., Newark  
 Woolf, Bernhardt H., 41 Hedden ter., Newark  
 Wort, Frederick J., 1080 Broad st., Newark

Wrench, Alexander E., 79 Valley rd., Montclair  
Wright, Robert E., 173 Park av., East Orange  
Wurts, Margaret M., 189 Alexander av., Up. Montcl'r  
Wurzel, Milton, 295 Hunterdon st., Newark  
Wyatt, Joseph H., 135 Clinton av., Newark  
Wyker, Arthur W., 57 Park pl., Bloomfield  
Yaguda, Asher, 88 Clinton av., Newark  
Yankowitz, Michael, 718 So. 17th st., Newark  
Yates, Glen L., 270 Ridgewood av., Glen Ridge  
Yelin, Gabriel, 635 High st., Newark  
Zybulewski, Edmund A., 410 Bergen st., Newark

Ylvisaker, Lauritz S., 763 Broad st., Newark  
Yoskalka, Jack S., 107th Med. Reg., Cp. Livingst'n, La.  
Zager, Saul, 454 Hawthorne av., Newark  
Zehnder, A. Charles, 188 Roseville av., Newark  
Zimmer, William, 1 Hillside av., Newark  
Zimmerman, Coler, 52 N. Arlington av., E. Orange  
Zingali, John A., 55 Grove st., Montclair  
Zvaifler, Nathan, 46 Wilbur av., Newark  
Zweibel, Leonard, 871 South 11th st., Newark  
Zweig, Isidore, 22 Monticello av., Newark

### Number of Active Members and basis of representation, 1057.

#### Associate Members

Adelman, Nathan, 203 Renner av., Newark  
Baime, Jules E., 41 Renner av., Newark  
Balsamo, Joseph J., 224 S. 8th st., Newark  
Bender, Louis, 284 Ridgewood av., Newark  
Berlin, Morris R., 337 Hawthorne av., Newark  
Binder, Israel L., 173 Lafayette st., Newark  
Braun, Edgar M., 843 S. 17th st., Newark  
Bremer, Kenneth M., 85 S. Harrison st., E. Orange  
Burstein, Leo Q., 702 S. 15th st., Newark  
Cantelmo, Alphonse L., 207 S. Harrison st., E. Orange  
Ciccone, Edwin L., 261 Roseville av., Newark  
Dailey, Edward S., 485 Park av., Orange  
Dante, Pasquale, 393 Millburn av., Millburn  
DeLia, Emi'io, 25 Crane st., Newark  
Duffy, Edward P., Jr., 330 Washington av., Belleville  
Fritsch, Alfred, 82 Lyons av., Newark  
Gehl, Sidney H., 65 Wolcott ter., Newark  
Giardina, Vincent J., 11 Hill st., Newark  
Goodman, Kenneth, Mitchell Field, Long Island, N.Y.  
Gorten, Manfred L., 669 Elizabeth av., Newark  
Greenberg, Jacob L., 408 Leslie st., Newark  
Greenberg, Mortimer, 165 E. 19th st., Brooklyn, N.Y.  
Gruber, William L., 338 S. 19th st., Newark  
Hirsch, Theodore, 842 S. 13th st., Newark  
Holderith, Albert E., 19 W. Mt. Pleasant av., Liv'gst'n  
Jackson, Kenneth K., 158 S. Harrison st., E. Orange  
Johnson, Robert A., 5 Bloomfield av., Belleville  
Kaney, Emil N., 2 New Brier lane, Allwood  
Keim, William F., Jr., 25 Roseville av., Newark  
Wujciak, Henry J., 212 Van Buren st., Newark

Kelemen, Nicholas M., 315 Central av., E. Newark  
Kuperman, Henry L., 237 16th av., Newark  
Lee, Robert E., 24 Great Oak drive, Short Hills  
Lehman, David J., Jr., 1 Highwood rd., West Orange  
Long, John F., 205 N. 4th st., Harrison  
Maggio, Nicholas A., 130 Fleming av., Newark  
Masciocchi, Thos. A., U.S.A. Air Base, Savannah, Ga.  
Modeski, Chester J., 11 Hill st., Newark  
Moore, James A., 99 S. Mountain av., Montclair  
Murphy, Thos. W., Jr., 58 Old Short Hills rd., Sht. Hills  
Oransky, Marvin, 75th Med. Bn., Fort Knox, Ky.  
Quinn, Edward D., 323 Belleville av., Bloomfield  
Rigeron, D. George, 160 Franklin st., Bloomfield  
Rowe, Jack M., 27 Park pl., Bloomfield  
Rozsa, Stephen, 811 S. 18th st., Newark  
Saracino, Frank J., 124 Grand pl., Arlington  
Schwartz, Mortimer L., 450 Belmont av., Newark  
Self, Edward B., 370 Central av., Orange  
Silbermann, Maximilian, 82 Lyons av., Newark  
Silberner, Herbert B., 104 Hillside av., Newark  
Solomon, Harold, 249 Avon av., Newark  
Steiner, Herbert, 650 Stuyvesant av., Irvington  
Tansey, Wm. A., Jr., 54 Baltusrol way, Short Hills  
Tibor, Albert, 725 High st., Newark  
Tunis, Benno B., 5 Farley av., Newark  
Wagner, John, 48 Wilson av., Newark  
Weinstein, Leopold, 82 Lyons av., Newark  
Winter, Egon W., 825 S. 10th st., Newark  
Wuerthele, Virginia E., 301 Mt. Prospect av., Newark

#### Resigned

Bugbee, F. C.  
Foster, William S.

Pudney, William K.  
Robinson, Lindsay E.

Tomasulo, Gennaro L.

## GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

#### Active Members

Barrows, Victor I., 316 N. Broadway, Pitman  
Black, Maskell B., 128 E. High st., Glassboro  
Booth, George R., 219 Highland av., Westville  
Bowersox, Clarence A., 509 N. Broad st., Woodbury  
Broselow, Benjamin G., Delsea dr., Franklinville  
Burkett, J. Paul, 215 Delaware st., Woodbury  
Burkett, Wendell J., 16 W. Holly av., Pitman  
Campo, A. Guy, 401 Broadway, Westville  
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury  
Chalfant, Wm. P., Broadway & Crafton av., Pitman  
Collins, Louis K., 54 State st., Glassboro  
Crain, William E., 64 Cooper st., Woodbury

DiMarino, Anthony J., 735 Delaware st., Paulsboro  
Diverty, Henry B., 38 Cooper st., Woodbury  
Faux, Frederick J., 32 N. Columbia st., Woodbury  
Fisler, Charles F., 140 Maple st., Clayton  
Fooder, Horace M., 110 Main st., Williamstown  
Gairdner, Thos. M., 319 W. Broad st., Gibbstown  
Gillis, Alfred G., 19 Maple st., Clayton  
Harris, William G., Main st., Mullica Hill  
Hollinshed, Ralph K., 351 Broadway, Westville  
Hughes, Joseph F., 16 N. Broad st., Woodbury  
Hunter, Harold H., 114 W. Broad st., Paulsboro  
Lintz, Sidney Z., 525 Kings Highway, Swedesboro



Livengood, Baxter A., 64 Cooper st., Woodbury  
 Moore, Ralph L., 127 N. Broad st., Woodbury  
 Nelson, Harry, 36 Lupton av., Woodbury  
 Patterson, Isaac N., 230 Broadway, Westville  
 Pedrick, William W., 11 West st., Glassboro  
 Pegau, Paul M., 246 Briar Hill lane, Woodbury  
 Rhoads, S. Creadick, 104 Station av., Westville  
 Rogers, Dorothy M., 50 Cooper st., Woodbury  
 Ruttenberg, Louis, 19 Hopkins st., Woodbury  
 Serri, William S., N. Main st., Mullica Hill  
 Sheets, Cecil C., 213 W. Broad st., Paulsboro  
 Sherman, Fuller G., 204 Delaware st., Woodbury  
 Sinexon, Henry L., 36 W. Broad st., Paulsboro

Sirota, E. Bernard, 220 W. Broad st., Paulsboro  
 Sooy, L. Thomas, 202 W. Holly av., Pitman  
 Stewart, Irving J., 529 Kings Highway, Swedesboro  
 Ulmer, Chester I., 431 W. Broad st., Gibbstown  
 Underwood, J. Harris 509 N. Broad st., Woodbury  
 Ventura, Ralph C., 101 S. Main st., Glassboro  
 Wandall, Frederick G., 50 E. High st., Clayton  
 Weems, Don B., 105 E. Mantua av., Wenonah  
 Wentzell, J. Earl, 5 E. Mantua av., Wenonah  
 Whitaker, Henry J., 10 S. Broadway, Pitman  
 Wood, Oran A., 128 W. Broad st., Paulsboro  
 Wright, Herman W., 818 S. Broadway, Pitman  
 Zapf, Reville D., 100 W. Mantua av., Wenonah

Number of Active Members and basis of representation, 50.

## HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

### Active Members

Adler, Joseph, 933 Ave. C, Bayonne  
 Africano, Julius V., 2700 Hudson Blvd., Union City  
 Agolia, Michael W., 2201 Palisade av., Union City  
 Ainsley, H. Bryson, 246 Union st., Jersey City  
 Allen, Isaac L., 2601 Palisade av., Union City  
 Alpert, Edward, 661 Jersey av., Jersey City  
 Alter, Nicholas M., 410 Fairmount av., Jersey City  
 Amdur, Louis A., 2540 Boulevard, Jersey City  
 Angelo, Joseph A., Fort Knox, Kentucky  
 Anrig, Grace E., 613 Summit av., Union City  
 Arbeit, Sidney R., 56 Gifford av., Jersey City  
 Aria, Charles, 574 Bergen av., Jersey City  
 Aria, Michael H., 31 Glenwood av., Jersey City  
 Arndt, Frank R., 7500 Bergenline av., N. Bergen  
 Aronowitz, Harry T., 932 Ave. C, Bayonne  
 Artaserse, Geo. V., 185 Bergen av., Jersey City  
 Ash, Arthur F., 710 Boulevard E., Weehawken  
 Atwell, David R., 920 Hudson st., Hoboken  
 Auriemma, Michele, 419 Adams st., Hoboken  
 Bahnson, Conrad M., 170 Bowers st., Jersey City  
 Bailly, Emanuel, 400 60th st., West New York  
 Ballinger, Reeve L., 659 Kearny av., Arlington  
 Balsamo, Anthony J., 212 52nd st., West New York  
 Barbarito, Wm. N., 135 Bentley av., Jersey City  
 Barishaw, Samuel B., 25 Bentley av., Jersey City  
 Barone, Francis A., Air Corps School, Gr'nville, Miss.  
 Behrens, Herman H. E., 312 Webster av., Jersey City  
 Bellina, George L., 518 79th st., North Bergen  
 Ben-Asher, Solomon, 254 Bergen av., Jersey City  
 Bender, Max, 327 23rd st., Union City  
 Benjamin, Harold C., 59 Crescent av., Jersey City  
 Bergmeyer, Josef T., 422 64th st., West New York  
 Berlin, Joseph I., 2600 Hudson Blvd., Jersey City  
 Betcher, Albert, 135 Belmont av., Jersey City  
 Bigliani, Urban R., Fort Mason, San Francisco, Cal.  
 Bitten, Robert M., 33 Romaine av., Jersey City  
 Blakey, Abram P., 155 Wegman Pkwy., Jersey City  
 Blum, Milton, 310 Stegman Pkwy., Jersey City  
 Boland, Lucy E., 27 Washington av., Arlington  
 Bonanno, Peter J., 500 79th st., North Bergen  
 Bookrajan, Edw. N., 8027 Hudson Blvd., N. Bergen  
 Borrone, Milton G., 2695 Boulevard, Jersey City  
 Borshaw, Hyman, 108 Bentley av., Jersey City  
 Bortone, Frank, 2765 Hudson Blvd., Jersey City  
 Boselli, Emile H., 614 15th st., Union City  
 Botti, John A., 236 Summit av., Jersey City  
 Boyers, Sidney S., 4614 Blvd., Union City  
 Boyle, Francis L., 829 Boulevard, Bayonne  
 Bradasch, George A., 1415 Central av., Union City

Brady, Thomas S., 678 Ave. C, Bayonne  
 Brady, William A., 412 44th st., Union City  
 Braitman, Max, Fort Knox, Ky.  
 Brauer, Selig L., 2012 Blvd., Jersey City  
 Braunstein, Sigmund C., 427 57th st., W. New York  
 Braunstein, Wm. P., 1 Bellevue st., Weehawken  
 Brennock, Thos. McG., 3 Webster av., Jersey City  
 Bresev, Morris, 36 Stegman st., Jersey City  
 Brick, George J., 43 Cottage st., Jersey City  
 Brignola, Gerald C., Fort DuPont, Delaware  
 Brophy, Francis X., 55 Gifford av., Jersey City  
 Brozdowski, John J., 554½ Jersey av., Jersey City  
 Butler, Vincent P., 33 Bentley av., Jersey City  
 Campana, Vincent R., 442 Fairmount av., Jersey City  
 Cannon, Edward A., 7512 Hudson Blvd., N. Bergen  
 Caridi, Salvatore, 5135 Bergenline av., W. New York  
 Carr, Mary B., 1 Astor pl., Jersey City  
 Catlaw, J. Kenneth, 254 Montgomery st., Jersey City  
 Chapman, Ellis J., 203 Danforth av., Jersey City  
 Chayes, Sydney, 980 Ave. C, Bayonne  
 Christian, Henry A., Fort Jay, Governors Is., N. Y.  
 Cieri, Daniel S., 1515 Central av., Union City  
 Clark, Chas. C., 2301 New York av., Union City  
 Cohen, Herman, 489 Jersey av., Jersey City  
 Cohen, Herman N., 108 13th st., Hoboken  
 Cohen, Samuel, 343 Fairmount av., Jersey City  
 Cohen, Samuel A., 477 Jersey av., Jersey City  
 Connell, Emmet J., 2227 Hudson Blvd., Jersey City  
 Connell, John N., 26 Carlton av., Jersey City  
 Connolly, Thomas W., 921 Bergen av., Jersey City  
 Conti, Michael, 280 4th st., Jersey City  
 Conty, Anthony J., 318 48th st., Union City  
 Cosgrove, Robert A., Station Hosp., Ft. DuPont, Del.  
 Cosgrove, Samuel A., 88 Clifton pl., Jersey City  
 Coughlin, John P., 160 Wegman Pkwy., Jersey City  
 Cracco, Frederick A., 211 Palisade av., Union City  
 Crisonino, Philip D., 2815 Blvd., Jersey City  
 Crowley, Leo F., 148 Belmont av., Jersey City  
 Cufari, Carmine J., 725 18th st., Union City  
 Culver, S. Herbert, 75 Magnolia av., Jersey City  
 Cupaiuoli, Richard A., Navy Base, Iceland  
 D'Acerno, Pellegrino A., 1708 Palisade av., Union City  
 Daly, Edmund J., 921 Bergen av., Jersey City  
 Danielson, John J., 4703 Tonnele av., North Bergen  
 Davey, Thomas N., 41 West 33rd st., Bayonne  
 DeFuccio, Charles P., 12 Duncan av., Jersey City  
 DeFusco, G. Thomas, U. S. Army  
 DeMarco, Silverino V., 1818 Boulevard, Jersey City  
 DeMeritt, Charles L., 4500 Boulevard, Union City



Dexter, Harriet E. T., 903 Ave. C, Bayonne  
Dillingham, Willis I., 431 59th st., West New York  
Dodson, Louis W., 592 Jersey av., Jersey City  
Dolganos, Moses, 268 Palisade av., Jersey City  
Donnelly, Joseph P., 58 Kensington av., Jersey City  
Donohoe, Lucius F., 33 Dodge st., Bayonne  
Doody, Wm. M., 19 Bentley av., Jersey City  
Doran, Ralph J., 200 11th st., Hoboken  
Doran, Wm. G., 2685 Boulevard, Jersey City  
Dougherty, Daniel D., 1006 Garden st., Hoboken  
Doyle, John J., 426 Fairmount av., Jersey City  
Draesel, Charles, 9027 Hudson Blvd., North Bergen  
Driscoll, Raymond S., 919 Hudson Blvd., Bayonne  
Duckett, Warren J., 21 Carlton av., Jersey City  
Dukes, Howard R., 220 Kearny av., Kearny  
Edgar, Joseph A., 71 Congress st., Jersey City  
Edwards, Lena F., 358 Pacific av., Jersey City  
Elsasser, Theodore H., 7206 Park av., North Bergen  
Enright, James G., 25 Kensington av., Jersey City  
Evans, J. Lawrence, 7117 Park av., North Bergen  
Faber, Edward, 154 Bergen av., Jersey City  
Facciolo, Frank, 562 Hudson Blvd., Bayonne  
Faison, John B., 45 Glenwood av., Jersey City  
Farr, John C., 1111 Bloomfield st., Hoboken  
Fattel, Henry C., 8300 Hudson Blvd., N. Bergen  
Fauquier, Leonard B., 172 Jewett av., Jersey City  
Federer, John J., 69 Columbia ter., Weehawken  
Feinberg, Harry, 73 W. 32nd st., Bayonne  
Felitti, Vincent J., 6 75th st., North Bergen  
Feller, William, 283 Bergen av., Jersey City  
Fenimore, Edward D., 77 Grace st., Jersey City  
Fialk, Harry, 4816 Hudson av., Union City  
Ficke, Sylvia A., 884 Summit av., Jersey City  
Fifer, William T., 746 Ave. C, Bayonne  
Fineberg, Bernard J., 113 Bentley av., Jersey City  
Fineberg, Jacob C., 50 Glenwood av., Jersey City  
Finger, Frederick A., 938 Ave. C, Bayonne  
Finke, Chas. H., 317 York st., Jersey City  
Finn, Frederick A., 54 Duncan av., Jersey City  
Finn, Henry R. W., 84 Lembeck av., Jersey City  
Flichtenfeld, Morris, 283 Fourth st., Jersey City  
Flicker, David J., Station Hosp., Cp. Blanding, Fla.  
Fliegel, Hilda C., 309 Baldwin av., Jersey City  
Frank, Morris, 920 Ave. C, Bayonne  
Frank, Nathan, 180 Bowers st., Jersey City  
Franklin, I. Harold, 191 Palisade av., Jersey City  
Freeman, Joseph, 146 W. 32nd st., Bayonne  
Freyberger, George A., 29 48th st., Weehawken  
Frieman, Hyman, 744 Ave. C, Bayonne  
Frutig, Harold C., 508 80th st., North Bergen  
Furman, Sol T., 349 Fairmount av., Jersey City  
Gerne, Timothy A., 972 Summit av., Jersey City  
Gerner, Harry E., 2600 Boulevard, Jersey City  
Ghee, Euclid P., 115 Claremont av., Jersey City  
Ginsberg, George, 624 Bloomfield st., Hoboken  
Gleeson, William J., 640 Bergen av., Jersey City  
Gnassi, Angelo M., 130 Wegman Pkwy., Jersey City  
Goldowsky, Ira, 23 Warner av., Jersey City  
Goldsmith, Alfred S., 1st M'd.Bn., M'rine F., N. River, N.C.  
Goldstein, Joseph D., Camp Claiborne, La.  
Goldstone, Karl H., 16 62nd st., West New York  
Good, Richard, 4619 Park av., Union City  
Goodrich, Stewart L., 812 Ave. C, Bayonne  
Gordon, Isaac L., 1815 Boulevard, Jersey City  
Gorenberg, Harold, 126 Gifford av., Jersey City  
Granelli, Humbert A., 213 Garden st., Hoboken  
Greenberg, Philip, 1902 Hudson Blvd., Jersey City  
Greenberg, Solomon, Fort McClellan, Alabama  
Greene, Albert D., 195 Palisade av., Union City  
Greene, Harry, 90 Duncan av., Jersey City  
Grieco, Emil H., 196 Broadway, Bayonne  
Grossman, Morris, 921 Bergen av., Jersey City  
Grossman, Rubin, 377 Ave. C, Bayonne  
Gurley, Katharine A., 2671 Blvd., Jersey City  
Gutmann, Erwin K., 3258 Blvd., Jersey City

Hall, Perry O., 2553 Boulevard, Jersey City  
Halligan, Earl J., 254 Montgomery st., Jersey City  
Halligan, Harold J., 254 Montgomery st., Jersey City  
Halperin, David, 590 Bergen av., Jersey City  
Halpern, Sophia L., 1311 Palisade av., Union City  
Handler, Harry, 305 York st., Jersey City  
Harter, Louis F., 174 Bowers st., Jersey City  
Hartwell, H. Ameroy, 777 Boulevard, E., Weehawken  
Harvey, John W., 818 Ave. C, Bayonne  
Harz, William V., 817 Ave. C, Bayonne  
Hasking, Arthur P., 318 Montgomery st., Jersey City  
Hauptman, Harry, 63rd & Walnut sts., Phila., Pa.  
Hekimian, Jacob H., 2314 Palisade av., Union City  
Hernandez, Manuel, 1974 Boulevard, Jersey City  
Herradora, Juan R., 2787 Boulevard, Jersey City  
Higgins, Gerald L., 1921 Blvd., Jersey City  
Higgins, John T., 145 Highland av., Jersey City  
Higgins, Thomas A., 2616 Hudson Blvd., Jersey City  
Hill, William F., 108 Grand av., Jersey City  
Hillel, Joseph, 464 Woodcliff av., Hudson Heights  
Hirsch, Solomon, 109 Van Wagenen av., Jersey City  
Holland, Moses H., Billings Hosp., Ft. Harrison, Ind.  
Hollywood, Jas. L., 219 Danforth av., Jersey City  
Hoops, Harold J., 2203 Hudson Blvd., Jersey City  
Howeth, John L., 14 Duncan av., Jersey City  
Imhoff, John G., 913 Summit av., Jersey City  
Introcaso, Dominick A., 45 Crescent av., Jersey City  
Ishkhanian, Nouri I., 6032 Palisade av., W. New York  
Jacks, Oscar, 476 Mercer st., Jersey City  
Jaffe, Benjamin, 566 Bergen av., Jersey City  
Jaffe, Herman M., 2600 Boulevard, Jersey City  
Jaffin, Abraham E., 41 Emory st., Jersey City  
Jaques, J. Eugenia, 74 Waverly st., Jersey City  
Jensen, Grover H., 451 Bergen av., Jersey City  
Jentz, John H., 63 Sherman pl., Jersey City  
Johnson, Archie W., 169 Claremont av., Jersey City  
Jones, Clement M., 454 Boulevard, Bayonne  
Jones, J. Morgan, Valley rd., Oakland  
Joseph, Benj. M., 2771 Hudson Blvd., Jersey City  
Judy, Kenneth H., 786 Ave. C, Bayonne  
Justin, Arthur W., 41 Fulton st., Weehawken  
Kainer, Herbert, 851 Boulevard, E., Weehawken  
Kanengiser, Clifford H., 8606 Blvd., North Bergen  
Kaplan, Herman B., 324 44th st., Union City  
Katz, Jacob D., 115 Fairview av., Jersey City  
Kearney, John V., 335 78th st., North Bergen  
Keegan, Thomas D., 8 Gifford av., Jersey City  
Keeney, James C., 1201 Park av., Hoboken  
Kelley, Chas. B. P., 921 Bergen av., Jersey City  
Kelly, Bernard S., 1954 Boulevard, Jersey City  
Kelly, Harry R. J., 311A Brown st., Union City  
Kennedy, John W., 520 West View av., Grantwood  
Kerdasha, George S., 131 75th st., Woodcliff  
Kiely, Eugene M., 800 Hudson st., Hoboken  
Kimmel, M. Leonard, 142 Manhattan av., Jersey City  
Klein, Julius, 1415 Palisade av., Union City  
Kolb, John M., 3977 Blvd., N. Bergen  
Kooperman, Barnett, 321 60th st., West New York  
Kooperstein, Samuel I., 191 Palisade av., Jersey City  
Koppel, Joseph A., 42 Highland av., Jersey City  
Kraemer, Samuel H., 309 Baldwin av., Jersey City  
Kraut, Arthur M., Mitchell Field, Long Island, N.Y.  
Kresch, Philip, 42 West 22nd st., Bayonne  
Kruger, Alfred L., 100 Clifton pl., Jersey City  
Kuhlmann, Alvin E., 527 37th st., Union City  
Kun, Bertram, 135 Belmont av., Jersey City  
Lakiszak, Roman T., 253 Stegman st., Jersey City  
Landshof, Chas. A., 50 Glenwood av., Jersey City  
Lane, Thomas F., 145 Garrison av., Jersey City  
Lange, Louis C., 50 Clifton ter., Weehawken  
Largay, Arthur O., 937 Ave. C, Bayonne  
Larkey, Charles J., 700 Ave. C, Bayonne  
Lawsing, G. Conde, 443 22nd st., West New York  
Lefkowitz, Jacob H., 445 64th st., West New York  
Leining, Albert, 45 48th st., Weehawken

- Leir, J. Krevin, 9 Garrison av., Jersey City  
 Levine, G. Irving, 2017 Hudson Blvd., Jersey City  
 Linden, Mortimer H., 45 Clendenny av., Jersey City  
 Lindroth, Lawrence V., 4633 Hudson Blvd., N. Berg'n  
 Lipshutz, Benjamin, 18 West 22nd st., Bayonne  
 Lipshutz, Charles, 804 Ave. C, Bayonne  
 Lobban, Robert B., 2595 Boulevard, Jersey City  
 Londrigan, Joseph F., 832 Bloomfield st., Hoboken  
 Londrigan, Joseph F., II, 832 Bloomfield st., Hobok'n  
 Long, Miles T., 2150 Hudson Blvd., Jersey City  
 Loori, Wm. A., 549 Pavonia av., Jersey City  
 Luczynski, Edw. W., 28 E. 22nd st., Bayonne  
 Luippold, Eugene J., 35 Columbia ter., Weehawken  
 Lupin, Edward E., 930 Blvd., Bayonne  
 Lynch, Roland J., Mental Disease Hosp., Secaucus  
 Lynn, Irving I., 2252 Boulevard, Jersey City  
 Macchia, Benjamin J., 358 Arlington av., Jersey City  
 MacDonald, John J., 348 Ogden av., Jersey City  
 Mackin, John J., 596 Bergen av., Jersey City  
 Madaras, John S., 870 Ave. C, Bayonne  
 Madden, William L., 83 Gifford av., Jersey City  
 Madison, L. Keith, 358 Pacific av., Jersey City  
 Maras, Peter E., 80 Tonnele av., Jersey City  
 Margolin, Samuel J., 1012 80th st., North Bergen  
 Markowitz, Benj. B., 116 Gifford av., Jersey City  
 Markowitz, Irwin B., 2157 Hudson Blvd., Jersey City  
 Marshall, Frank A., Flight Surgeon, Dothan, Ala.  
 Mastromonaco, Joseph D., 790 Ave. C, Bayonne  
 Matera, Joseph, 506 Garden st., Hoboken  
 Mathesheimer, Jacob L., 280 Old Bergen rd., Jer. City  
 Mathews, William J., 938 Hudson st., Hoboken  
 Matturri, Dominick A., 81 Gifford av., Jersey City  
 Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne  
 Maver, William W., 532 Bergen av., Jersey City  
 McCarron, James A., 341 Ave. A, Bayonne  
 McCarthy, Cornelius P., 887 Boulevard, Bayonne  
 McLean, Herbert E., 92 Fairview av., Jersey City  
 McLean, Hugh A., 414 61st st., West New York  
 McLoughlin, Frank J., 558 Jersey av., Jersey City  
 McLoughlin, John W., 34 W. 32nd st., Bayonne  
 McNenney, Claudio E., 113 Fairview av., Jersey City  
 Meehan, George E., 117 Mercer st., Jersey City  
 Meltsner, Louis, 904 Hudson st., Hoboken  
 Meltzer, Louis, 32 W. 33rd st., Bayonne  
 Mersheimer, Christian H., 15 Reservoir av., Jer. City  
 Meyer, William, 2128 New York av., Union City  
 Meyerson, Noah, 428 59th st., West New York  
 Mickewich, Stephen A., 650 Ave. C, Bayonne  
 Miller, Max H., 311 60th st., West New York  
 Monfort, Robert N., 155 Van Wagenen av., Jer. City  
 Morganstein, Louis K., 20 W. 22nd st., Bayonne  
 Morley, Grace C., 64 Clifton ter., Weehawken  
 Morris, David G., 11 W. 26th st., Bayonne  
 Mount, Elmer M., 74 Sherman pl., Jersey City  
 Muccia, John J., 7 Tonnele av., Jersey City  
 Mueller, George H., 102 Summit av., Jersey City  
 Murphy, James M., 2757 Boulevard, Jersey City  
 Murphy, Leo J., 1814 West st., Union City  
 Murphy, Patrick H. W., 27 Jefferson av., Jersey City  
 Murray, Joseph A., 765 Ave. C, Bayonne  
 Mustermann, Otto H., 303 48th st., Union City  
 Muttart, George W., 702 Ocean av., Jersey City  
 Mutter, Alfred A., 75 Beech st., Arlington  
 Nafash, Shafeek, 406 Palisade av., Union City  
 Nalitt, David I., 28 West 33rd st., Bayonne  
 Newman, Abraham J., 132 Manhattan av., Jersey City  
 Nicholson, Frank P., 895 Summit av., Jersey City  
 Nobile, James J., 913 Hudson st., Hoboken  
 Norton, James F., 58 Kensington av., Jersey City  
 Nuse, Edward F., 550½ Jersey av., Jersey City  
 Ockene, Abraham, 2415 Palisade av., Union City  
 O'Connor, John J., 2124 New York av., Union City  
 O'Gorman, Michael W., 46 Mercer st., Jersey City  
 O'Grady, Benson J., 931 Washington st., Hoboken  
 O'Hanlon, George, Medical Centre, Jersey City  
 Olpp, Arch. E., 1516 Bergenline av., Union City  
 O'Neill, John H., 270 Montgomery st., Jersey City  
 Ortolano, James J., 907 Washington st., Hoboken  
 O'Shea, John J., 2200 Palisade av., Weehawken  
 Oshrin, Henry, 6059 Park av., West New York  
 Osterreicher, Desider, 427 Bergen av., Jersey City  
 O'Sullivan, John R., 11 Quincy av., Arlington  
 Owen, Logan S., 938 Hudson st., Hoboken  
 Pacicco, Michele, 376 Monmouth st., Jersey City  
 Padney, Edward V., 452 Jersey av., Jersey City  
 Pagliughi, John J., 401 18th st., Union City  
 Pearlstein, Frank, 325 60th st., West New York  
 Pearson, J. Gerald, 819 Washington st., Hoboken  
 Perkel, Louis L., 2801 Hudson Blvd., Jersey City  
 Perlberg, Harry J., 921 Bergen av., Jersey City  
 Perrone, Arthur F., 415 60th st., West New York  
 Peters, Edgar A. P., 394 Bergen av., Jersey City  
 Peterson, Chas. A., 921 Washington st., Hoboken  
 Piltz, George F., 153 69th st., Guttenberg  
 Pindar, Frederick S., 7500 Park av., Woodcliff  
 Pindar, William A., 7523 Broadway, North Bergen  
 Pinkerton, Wm. A., 854 Ave. C, Bayonne  
 Piskorski, Abdon V., 604 Jersey av., Jersey City  
 Plavin, Nathan J., 8010 Hudson Blvd., No. Bergen  
 Pollak, Berthold S., 100 Clifton pl., Jersey City  
 Pontery, Herbert B., 89 Bowers st., Jersey City  
 Potter, Benjamin P., 100 Clifton pl., Jersey City  
 Povalski, Alex. W. T., 1925 Boulevard, Jersey City  
 Preece, John D., 39 Gifford av., Jersey City  
 Price, H. Preston, 591 Montgomery st., Jersey City  
 Prince, Samuel, 516 34th st., Union City  
 Purdy, Charles H., 35 Highland av., Jersey City  
 Pyle, Louis A., 89 Fairview av., Jersey City  
 Pyle, Wallace, 15 Exchange pl., Jersey City  
 Quigley, Frederic J., 543 45th st., Union City  
 Quinn, John J., 921 Bergen av., Jersey City  
 Read, Donald B., 105 Hudson st., Jersey City  
 Reingold, Alexander, 221 Garden st., Hoboken  
 Reitnauer, John S., 518 44th st., Union City  
 Rieck, Walter R., 379 Kearny av., Kearny  
 Rieman, Aloysius P., 3566 Boulevard, Jersey City  
 Robbins, Henry B., 144 Mercer st., Jersey City  
 Rosen, Chas. E., 1513 Palisade av., Union City  
 Rosenberg, Albert B., 69 Myrtle av., N. Plainfield  
 Rosenberg, Jacob, 692 Bergen av., Jersey City  
 Rosenstein, Jacob L., 568 Bergen av., Jersey City  
 Rubenstein, Eli, 800 Ave. C, Bayonne  
 Rubenstein, Robert, 2758 Blvd., Jersey City  
 Ruffer, Ralph A., 1406 West st., Union City  
 Rundlett, Emilie V., 79 Prospect st., Jersey City  
 Ruoff, Andrew C., 2414 New York av., Union City  
 Russell, David L., 690 Bergen av., Jersey City  
 Ruvane, Joseph J., 38 Bentley av., Jersey City  
 Sabini, Cecil F., 257 4th st., Hoboken  
 Sacco, Anthony G., 2200 New York av., Union City  
 Sachs, Wilbert, 921 Bergen av., Jersey City  
 Sager, Harold, 19 W. 22nd st., Bayonne  
 Santangelo, Stephen, 461 Jersey av., Jersey City  
 Santosky, Benj. B., 20 Tonnele av., Jersey City  
 Saradarian, Albert V., Ft. Jay, Governors Island, N.Y.  
 Scheer, Eli, 7332 Hudson Blvd., North Bergen  
 Schenker, Benjamin N., 246 5th st., Jersey City  
 Schenker, Israel N., 3697 Blvd., Jersey City  
 Schept, Samuel S., 523 37th st., Union City  
 Schlein, August, 707 Park av., Hoboken  
 Schneckenendorf, Samuel J., 179 Harrison av., Jer. C'y  
 Schneider, Louis A., 412 61st st., West New York  
 Schuchner, Wm. F., 550½ Jersey av., Jersey City  
 Schuck, Traugott J., 58 Ninth st., Hoboken  
 Schulman, Abraham S., 4518 Boulevard, Union City  
 Schurman, Emil W., 710 Ocean av., Jersey City  
 Schwarz, Berthold T. D., 2787 Blvd., Jersey City  
 Schwarz, Henry J., 8534 Hudson Blvd., N. Bergen  
 Sciarrillo, Louis F., 711 Garden st., Hoboken  
 Sciorsci, Edward F., 609 Bloomfield st., Hoboken



Scott, Samuel G., 141 Bergen av., Jersey City  
Seligmann, Fred S., 501 32nd st., Union City  
Selinger, Samuel, 413 60th st., West New York  
Shapiro, Maurice, 750 Ave. C, Bayonne  
Shapiro, Nathaniel J., 212 Palisade av., Union City  
Shapiro, Saul J., 1215 Palisade av., Union City  
Sheeran, Vincent J., 269 Jewett av., Jersey City  
Shook, Benjamin E., 284 Bergen av., Jersey City  
Shulman, Nathan L., 533 45th st., Union City  
Siegel, Lester, 645 Bergen av., Jersey City  
Siegler, Julius, 646 Bergen av., Jersey City  
Sigman, George, 2149 Blvd., Jersey City  
Silich, Robert L., 19 48th st., Weehawken  
Simeone, Peter A., 555 38th st., Union City  
Simpson, David B., 1st Med. Bn., Ft. Devens, Mass.  
Singer, Sina S., 3443 Hudson Blvd., Jersey City  
Smith, Alex. L., 2672 Hudson Blvd., Jersey City  
Smith, Arthur B. R., U.S. Sub. Base Hosp., N. L. d'n, Conn.  
Snyder, John E., 1023 Garden st., Hoboken  
Snyder, W. Jay, 74 Columbia ter., Weehawken  
Spalding, Henry J., 512 45th st., Union City  
Spano, Frank, 320 47th st., Union City  
Spath, William H., 722 Hudson st., Hoboken  
Spence, Henry, 2540 Hudson Blvd., Jersey City  
Spohn, Eugene L., Veterans' Amd., Washington, D.C.  
Sprague, Seth B., 301 York st., Jersey City  
Stankiewicz, F. Stanley, 554½ Jersey av., Jersey City  
Stark, Harry L., 680 Hudson Blvd., Bayonne  
Starr, Benjamin, 96 Sherman place, Jersey City  
Stefansin, Frank, 3975 Hudson Blvd., N. Bergen  
Stein, Albert, 700 85th st., North Bergen  
Stein, Jacob M., 68 Columbia ter., Weehawken  
Stockfisch, Robert H., 3637 Boulevard, Jersey City  
Stokes, Anthony T., 819 First st., Secaucus  
Stout, J. Phillip, 165 Jewett av., Jersey City  
Street, Daniel B., 27 Woodlawn av., Jersey City  
Stuart, William C., 518 Hudson st., Hoboken  
Sullivan, James A., 46 Bentley av., Jersey City  
Sulouff, S. Henry, 662 Newark av., Jersey City  
Sussman, Harold, 541 44th st., Union City  
Sweeney, William J., 68 Clifton ter., Weehawken

Swiney, Juliana C., 325 Ave. C, Bayonne  
Swiney, Merrill A., 325 Ave. C, Bayonne  
Taft, Herman L., 4605 Hudson Blvd., N. Bergen  
Talty, John C., 935 Washington st., Hoboken  
Tannert, Carl H., 331 77th st., North Bergen  
Tataryan, Hovsep, 2024 New York av., Union City  
Temes, J. Howard, 2216 Boulevard, Jersey City  
Thomas, Ralph B., 793 Montgomery st., Jersey City  
Tidwell, Harold F., 229 60th st., West New York  
Timlin, James W., 64 Beech st., Arlington  
Tomaluoli, Michele, 19 76th st., North Bergen  
Tyndall, Hugh H., 83 Highwood ter., Weehawken  
Urevitz, Abraham, 2415 New York av., Union City  
Utkewicz, Edmond A., 2633 Hudson Blvd., Jersey City  
Varriano, John L., 3263 Hudson Blvd., Jersey City  
Visconti, Joseph A., 711 Garden st., Hoboken  
Vostrosablin, Nicholas A., 121 Grand st., Jersey City  
Vreeland, William N., 32 Bergen av., Jersey City  
Wallack, Eli A., 333 Fairmount av., Jersey City  
Walscheid, Arthur J., 404 38th st., Union City  
Waters, Edward G., 39 Gifford av., Jersey City  
Watman, Anthony J., 2784 Boulevard, Jersey City  
Weber, Walter D., 305 23rd st., Union City  
Wechsler, Joseph, 3342 Hudson Blvd., Jersey City  
Weiss, Abram, Naval Station, Key West, Fla.  
Weiss, Morris J., 734 Ave C, Bayonne  
Welcher, Howard A., 7904 Hudson Blvd., N. Bergen  
Wheeler, James A. V., 85 Van Reypen st., Jersey City  
White, Hugh M., 901 Summit av., Jersey City  
White, Thomas J., 50 Glenwood av., Jersey City  
Wilcox, Frank A., 329 60th st., West New York  
Williamson, Wm. L., 22 W. 22nd st., Bayonne  
Woelfle, Henry E., 907 Summit av., Jersey City  
Wolbert, Charles M., 691 Palisade av., Cliffside Park  
Woltz, Sidney, 2202 Palisade av., Weehawken  
Woodruff, Stanley R., 16 Enos pl., Jersey City  
Yeaton, Wm. L., Jr., 204 11th st., Hoboken  
Yontef, Reuben, Fort Jackson, S. C.  
Yudkoff, William, 403 Hudson Blvd., Bayonne  
Yunck, William P., Jr., 921 Bergen av., Jersey City  
Zitani, Alfred M., 937 Washington st., Hoboken

Number of Active Members and basis of representation, 480.

#### Honorary Members

Axford, W. Homer, St. Petersburg, Florida  
Connell, John, Jersey City  
Gille, Hugo, Jersey City  
Miner, Donald, New York City  
Oestmann, August W., Jersey City

Older, Benjamin, Miami Beach, Florida  
Rosecrans, James H., Hoboken  
Sexsmith, George H., Los Angeles, California  
Vreeland, Hamilton, Ridgewood  
Zenneck, Junius F., Weehawken

#### Transfer

Fliegel, Hilda C., from New York County

### HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

#### Active Members

Baker, Philip W., High Bridge  
Bambara, Aurelius J., Flemington  
Beatty, Hannah J., Clinton Farms, Clinton  
Boothby, I. Roland, Clinton  
Boyer, Charles G., Annandale  
Christensen, Alexander H., Lebanon  
Clark, Frank G., White House Station  
Coleman, Austin H., Clinton  
Ctibor, Vladimir F., Califon

English, Sam'l B., N. J. State Hospital, Glen Gardn'r  
Fluck, Paul H., 73 N. Union st., Lambertville  
Fritz, John F., Jr., 95 Main st., Flemington  
Fuhrmann, Barclay S., 10 Main st., Flemington  
Garfinkel, Abraham, 30 Broad st., Flemington  
Germain, Raymond J., High Bridge  
Hamilton, Lloyd A., 46 York st., Lambertville  
Heil, Alva A., Milford  
Henry, George, 33 Mine st., Flemington



Jenkins, Arthur M., 701 Harrison st., Frenchtown	McCorkle, William E., Ringoes
Knox, Howard A., New Hampton	Merrill, Edwin D., Milford
Landry, Ernest J., N. J. State Hosp., Glen Gardner	Mullins, Roy L., 305 Harrison st., Frenchtown
Lane, Edgar W., 46 Main st., Bloomsbury	Shangold, Jack E., Sergeantsville
Tompkins, Grenelle B., 52 Broad st., Flemington	

**Number of Active Members and basis of representation, 27.**

**Honorary Members**

Morrison, J. Bennett, Carlsbad, California	Scammell, Frank G., Trenton
Sommer, George N. J., Trenton	

**Transfers**

Cartisser, J. J., to Sussex County	Smith, Ivan B., to Middlesex County
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**MERCER COUNTY (11)**

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 8:30 p. m., in the Stacy-Trent Hotel. Annual Meeting in December. Annual Banquet in November.

**Active Members**

Abey, W. J. H., 21 E. Delaware av., Pennington	Cotton, Henry A., Jr., L'wr'nc'ville-Pr'nct'n rd., Pr'n
Ackley, David B., 21 N. Clinton av., Trenton	Cottone, Rosario J., 683 Princeton av., Trenton
Albert, Perry, 2780 S. Broad st., Trenton	Cowlbeck, Harry D., 224 W. State st., Trenton
Applegate, Edw. T. R., 1125 Greenwood av., Trenton	Cox, Harold C., 208 Stockton st., Hightstown
Applestein, Robert, 568 E. State st., Trenton	D'Arcy, Walter E., 545 E. State st., Trenton
Aronis, Harry R., 542 W. State st., Trenton	Davenport, Irwin P., 545 W. State st., Trenton
Ashley, Harmon H., 20 Nassau st., Princeton	Davis, Harold L., 178 W. State st., Trenton
Austin, Henry J., 96 Bellevue av., Trenton	Davis, John E., Jr., 102½ Beaufinn st., Charleston, S.C.
Barrows, Arthur M., 440 Hamilton av., Trenton	Davison, Royden W., 205 W. State st., Trenton
Barry, R. Grant, 908 W. State st., Trenton	Dean, Guy K., Jr., Princeton rd., Plainsboro
Bayne, Joseph K., 185 Rosemont av., Trenton	Deitz, Joseph R., 320 Centre st., Trenton
Beairsto, Everett B., 224 W. State st., Trenton	Dembinski, T. Henry, 221 Maple av., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton	Denelsbeck, J. Otis, 878 E. State st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton	Dimun, John T., Port of Embark., New Orleans, La.
Bellis, Horace D., 437 E. State st., Trenton	Dodge, James T., 1819 S. Broad st., Trenton
Bennett, Robert E., N. J. State Hospital, Trenton	Doranz, Harold K., 491 Centre st., Trenton
Bergsma, Daniel, 1 W. State st., Trenton	Drezner, Henry L., 507 S. Warren st., Trenton
Berman, Jacob J., 409 Market st., Trenton	Eames, William N., 1871 Pennington rd., Trenton
Berry, Leonard M., 205 Nassau st., Princeton	Elias, Elmer J., 156 F'd Art., No. 44, Cp. Claiborne, La.
Blackwell, Enoch, 28 W. State st., Trenton	Engelhart, Ferdinand K., 701 Stuyves't av., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton	English, Harrison F., III, Ch't'r'f'd-S'k'v'le rd., Ch'st'd
Blum, Joseph M., 128 Mill st., Trenton	Epstein, Rubie, 606 Perry st., Trenton
Bonnet, W. Laurence, 2791 Not'gh'm wy., Merc'ville	Ernest, Richard B., 240 W. State st., Trenton
Borrella, Dominic D., 476 Hamilton av., Trenton	Fabian, Paul L., 520 Princeton av., Trenton
Buckley, Richard T., Jr., Peddie Sch'l, Hightstown	Farmer, Walter D., 28 S. Main st., Allentown
Burbridge, J. Raymond, McCosh Infirmary, Princeton	Fell, Alton S., 912 Riverside av., Trenton
Burns, Joseph R., 46 S. Olden av., Trenton	Fessler, A. James, 1544 S. Broad st., Trenton
Burroughs, Edmund W., 701 W. State st., Trenton	Fine, Sydney G., Hospital No. 2, Ft. Bragg, N. C.
Byer, M. Yale, 827 E. State st., Trenton	Finegan, Paul J., 200 W. State st., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton	Finkle, Lester J., 225 Perry st., Trenton
Carroll, C. Walter, 125 Centre st., Trenton	Fiorello, Joseph R., 689 Princeton av., Trenton
Carroll, William V., 211 Academy st., Trenton	Fluck, David A., 626 W. State st., Trenton
Cella, Charles F., 359 Hamilton av., Trenton	Forer, Robert, 247 Centre st., Trenton
Charleroy, Durant K., 38 Crosswicks st., Bordentown	Franzoni, Andrew E., Box 375, c/o Davis, LeCompte, La.
Chesner, Wm. A., 1111 Hamilton av., Trenton	Friedman, Max, 493 Chambers st., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton	Friedman, Meyer H., 526 N. Clinton av., Trenton
Clark, Alice L., 206 W. State st., Trenton	Friedmann, Leonard L., 484 Princeton av., Trenton
Clark, Charles E., New Jersey State Hosp., Trenton	Fuchs, Jacob N., 1267 S. Broad st., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton	Garwood, Norman W., Main st., Crosswicks
Cohen, Herman, 1301 Hamilton av., Trenton	Gindhart, John H., 1233 Hamilton av., Trenton
Cohen, William, 703rd Tank Bn., Camp Polk, La.	Goldberg, Ben. M., 1156 E. State st., Trenton
Colavita, James J., 433 Princeton av., Trenton	Goldman, Leo L., 325 Market st., Trenton
Collins, Henry J., 1160 Hamilton av., Trenton	Graham, Ernest E., 4273 S. Broad st., Yardville
Comfort, John B., 50 S. Clinton av., Trenton	Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Commini, Frank F., 741 Centre st., Trenton	Guidotti, Frank P., 703 Hamilton av., Trenton
Connelly, John A., 212 W. State st., Trenton	Hafetz, M. Morris, 114 Centre st., Trenton
Corio, George A., 307 S. Clinton av., Trenton	Haggerty, D. Leo, 227 N. Warren st., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton	Haines, Evelyn M., 1022 Greenwood av., Trenton

- Hammell, Frank M., 137 S. Main st., Allentown  
 Haney, John J., 850 Hamilton av., Trenton  
 Harman, James R., 824 W. State st., Trenton  
 Harman, William J., 740 W. State st., Trenton  
 Harrop, George A., 33 Cleveland lane, Princeton  
 Hess, George A., River rd., Titusville  
 Hiden, Joseph C., 199 Nassau st., Princeton  
 Hirschfield, Bernard A., 438 Hamilton av., Trenton  
 Horhovit, George I., 324 S. Broad st., Trenton  
 Hunter, Floyd D., 3620 Nottingham way, Hamilt'n Sq.  
 Hutchinson, A. Dunbar, 913 W. State st., Trenton  
 Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.  
 Ivins, William C., 455 W. State st., Trenton  
 James, J. Thos., Canterbury Hotel, San Francisco  
 Janoff, Henry, 626 Perry st., Trenton  
 Jaspán, Samuel C., 820 Division st., Trenton  
 Johnson, John F., 113 Abernethy dr., Trenton  
 Kachdorian, Vartan, 930 Brunswick av., Trenton  
 Kinczel, John A., 971 S. Broad st., Trenton  
 Klempner, Paul, 637 Greenwood av., Trenton  
 Kline, Joseph J., 733 Hamilton av., Trenton  
 Knauer, Charles H., Jr., 304 W. State st., Trenton  
 Kohn, Joseph J., 107 Market st., Trenton  
 Kohn, Ralph B., 107 Market st., Trenton  
 Kondor, Joseph S., 978 S. Broad st., Trenton  
 Koplin, A. Herman, Apt. R2, Colonial Vil., Columbia, S.C.  
 Koplin, Nathaniel H., 142 W. State st., Trenton  
 Kustrup, John F., 1418 S. Broad st., Trenton  
 Lapin, Louis P., 15 Crosswicks st., Bordentown  
 Lapin, Samuel B., 628 W. State st., Trenton  
 Larsson, Evert A., N. J. State Hospital, Trenton  
 Lavine, Barney D., 630 N. Clinton av., Trenton  
 Lavine, Sidney B., 144 W. State st., Trenton  
 Leshin, Harry, 564 S. Main st., Hightstown  
 Lettiere, Anthony J., 425 E. State st., Trenton  
 Levin, Louis, 651 W. State st., Trenton  
 Levy, Irvin, 154 W. State st., Trenton  
 Light, Arthur B., Lawrenceville School, Lawr'nc'e'ville  
 Little, William R., 493 W. State st., Trenton  
 Lloyd, Samuel J., 178 W. State st., Trenton  
 Lynch, Donald C., 885 Stuyvesant av., Trenton  
 MacDermid, Lynden, 506 Farnsworth av., Bordent'n  
 Magee, Harold S., New Jersey State Hosp., Trenton  
 Magson, Albert E., 302 S. Main st., Hightstown  
 Majeski, Henry J., 935 Brunswick av., Trenton  
 McCandliss, Wm. K., N. J. State Hospital, Trenton  
 McCarthy, Wm. P., 119 Med. Reg. No. 44, Cp. Claiborne, La.  
 McCullough, John H., 523 E. State st., Trenton  
 McGuigan, Francis A., 212 N. Warren st., Trenton  
 Means, Paul B., N. J. State Hospital, Trenton  
 Miller, Earle K., 2502 Nottingham way, Trenton  
 Miller, Gerald H., N. Main st., Cranbury  
 Miller, Reginald C., 1420 Greenwood av., Trenton  
 Miller, Samuel R., 407 S. Main st., Pennington  
 Minschwaner, Geo. G., Jr., 954 Greenw'd av., Trenton  
 Mitchell, Charles H., 1100 W. State st., Trenton  
 Mitskas, Theo. V. J., 1329 Greenwood av., Trenton  
 Moriconi, Albert F., 438 Hamilton av., Trenton  
 Mountford, Wm. E., 215 N. Warren st., Trenton  
 Munro, Jeannette, 2 Queenston pl., Princeton  
 Murphy, James A., 312 Bellevue av., Trenton  
 Murto, Thomas V., 532 W. State st., Trenton  
 Nayfield, Ronald C., 974 S. Broad st., Trenton  
 Nonziato, Frank A., 50 Centre st., Trenton  
 North, Harry R., 160 W. State st., Trenton  
 Ogden, Andrew E., 1829 Greenwood av., Trenton  
 O'Neill, Joseph F., 41 E. Broad st., Hopewell  
 O'Rourke, James J., 871 Stuyvesant av., Trenton  
 Pantaleone, Joseph, 504 Hamilton av., Trenton  
 Parker, Horace N., 72 N. Clinton av., Trenton  
 Pessel, Johannes F., 224 W. State st., Trenton  
 Peterson, Walter R., 312 W. State st., Trenton  
 Pierson, Carl L., 395 W. State st., Trenton  
 Pierson, Jos. R., 119th Med. Reg. No. 44, Cp. Claiborne, La.  
 Pinerman, Robert B., 308 W. State st., Trenton  
 Pittman, Allen R., N. J. State Hospital, Trenton  
 Potter, Ellen C., 301 W. State st., Trenton  
 Powis, Ethel M., 198 W. State st., Trenton  
 Poyas, Morton L., 306 W. State st., Trenton  
 Proctor, Francis E., 332 W. State st., Trenton  
 Purcell, Ernest F., 800 Stuyvesant av., Trenton  
 Ragany, Joseph, 966 S. Broad st., Trenton  
 Rainey, Willard G., 34 Bayard lane, Princeton  
 Rampona, Joseph M., 272 Nassau st., Princeton  
 Reisinger, Paul B., 369 W. State st., Trenton  
 Rita, James J., 235 S. Clinton av., Trenton  
 Rogers, Laurence H., Donnelly Mem. Hosp., Trenton  
 Rose, William G., 182 Stockton st., Hightstown  
 Rowan, Henry M., 224 W. State st., Trenton  
 Sackin, Stanley, 1009 Hamilton av., Trenton  
 Salway, Benjamin, 321 S. Broad st., Trenton  
 Scammell, Frank G., 40 S. Clinton av., Trenton  
 Scasserra, Benedict B., 163 Nassau st., Princeton  
 Schildkraut, Jacob M., 170 W. State st., Trenton  
 Seely, Roy B., 78 N. Clinton av., Trenton  
 Seitzick-Robbins, H. E., 723 W. State st., Trenton  
 Sekerak, Albert J., 984 S. Broad st., Trenton  
 Shear, M. Murray, 1158 E. State st., Trenton  
 Sica, L. Samuel, 431 E. State st., Trenton  
 Siemion, Theophilis R., 1005 Brunswick av., Trenton  
 Sill, John B., 942 W. State st., Trenton  
 Silver, E. Drew, 136 Stockton st., Hightstown  
 Sinton, John Y., Imlaystown  
 Slack, Clarence J., 230 W. State st., Trenton  
 Smith, Houghton C., 1063 S. Clinton av., Trenton  
 Smith, Paul E., Richmond State Hosp., Richm'd, Ind.  
 Smith, W. Henley, 126 W. State st., Trenton  
 Snegireff, Leonid S., 49 Maple av., Trenton  
 Sommer, Geo. N. J., 120 W. State st., Trenton  
 Sommer, Geo. N. J., Jr., 120 W. State st., Trenton  
 Spradley, Jeems B., N. J. State Hospital, Trenton  
 Steel, John M., N. J. State Hospital, Trenton  
 Stein, Louis A., 226 W. State st., Trenton  
 Stone, Robert G., N. J. State Hospital, Trenton  
 Storaci, Frank S., 715 Hamilton av., Trenton  
 Summers, Alfred D., 180 Nassau st., Princeton  
 Sutnick, Theodore B., 1018 S. Broad st., Trenton  
 Swern, Nathan, 399 W. State st., Trenton  
 Swertfeger, Herbert W., 22 N. Greenw'd av., Hopew'l  
 Taylor, Walter A., 450 Rutherford av., Trenton  
 Tenney, Luman H., 7015 Hilltop av., Upper Darby, Pa.  
 Tomec, Otto C., 756 Parkway av., Trenton  
 Treiber, Benjamin A., 219 W. State st., Trenton  
 Urbaniak, Henry S., 883 Brunswick av., Trenton  
 Vaczi, Stephen, 983 S. Broad st., Trenton  
 Vanneman, Joseph S., 45 Princeton av., Princeton  
 Vento, Sebastian J., 1330 S. Clinton av., Trenton  
 Vol-Tretter, Marta, 501 W. State st., Trenton  
 Waldron, Edward L., 126 W. State st., Trenton  
 Walsh, Thos. J., 119th Med. Reg. No. 44, Cp. Claiborne, La.  
 Warter, Peter J., 717 W. State st., Trenton  
 Waters, Chas. H., 928 W. State st., Trenton  
 Watov, Samuel E., 615 Beatty st., Trenton  
 Watson, Fred'k S., 238 W. State st., Trenton  
 Watts, Wilbur, 436 E. State st., Trenton  
 Wayman, Bernard R., 834 Stuyvesant av., Trenton  
 West, Edgar L., 443 E. State st., Trenton  
 Wiesler, Howard M., Drawer N, Trenton  
 Wikoff, John L., 799 Pennington av., Trenton  
 Wildmann, George A., 1739 S. Broad st., Trenton  
 Wilkes, LeRoy A., 143 E. State st., Trenton  
 Williams, Geo. W., 829 W. State st., Trenton  
 Williams, Harry D., 527 E. State st., Trenton  
 Wilner, Arthur S., 205 Market st., Trenton  
 Wilner, Irving, 205 Market st., Trenton  
 Wittenborn, W. F. J., 1635 Brunswick av., Trenton



Wolff, Herbert M., 732 W. State st., Trenton  
 Yaeger, Leslie A., 119th Med. Reg. No. 44, Cp. Claiborne, La.  
 Zimskind, Joshua N., 210 W. State st., Trenton  
 York, Wilbur H., 87 Battle rd., Princeton  
 Zandt, Frederic B., 16 Mercer st., Hamilton Square

### Number of Active Members and basis of representation, 247.

#### Associate Members

Charnock, Maurice P., 104 Perry st., Trenton  
 Ciuccarelli, Francesco, 225 Hamilton av., Trenton  
 Cohen, Joseph, 217 W. Hanover st., Trenton  
 Forman, Douglas N., N. J. State Hospital, Trenton  
 Irmisch, George W., Mercer Hospital, Trenton  
 Mark, George E., Jr., N. J. State Hospital, Trenton  
 Moore, John L., 38 Alexander st., Princeton  
 Pepe, Salvatore A., Co. G, 119th Med. Regt., Ft. Bragg, N.C.  
 Rowland, Edward G., N. J. State Hospital, Trenton  
 Wilson, Joseph G., N. J. State Hospital, Trenton

#### Honorary Members

Gordon, Clark H., Trenton  
 MacFarland, Burr W., Trenton  
 Pierson, Theodore A., Hopewell  
 Silver, George A., Hightstown  
 Turner, Irvine F. P., Titusville  
 Wright, Howard E., Princeton

#### Resigned

Wright, Ada V.

## MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

#### Active Members

Anderson, John F., 195 College av., New Brunswick  
 Avery, Philip S., Woodland ter., Bound Brook  
 Balogh, Wm. A., 32nd Div., Camp Livingston, La.  
 Bassett, Lavern C., 320 New Market rd., Dunellen  
 Belafsky, Henry A., 150 Green st., Woodbridge  
 Berkow, Samuel G., 138 Market st., Perth Amboy  
 Bowman, Ned O., 1001 Georges rd., New Brunswick  
 Breslow, Samuel, 157 Market st., Perth Amboy  
 Brody, Morton S., 67 Paterson st., New Brunswick  
 Brown, Fred. L., 67 Livingston av., New Brunswick  
 Burnett, Charles B., 109 Main st., South River  
 Calvin, Charles H., 80 Commerce st., Perth Amboy  
 Clarke, Francis M., 116 New st., New Brunswick  
 Cohen, Nathan B., 104 Market st., Perth Amboy  
 Cooper, Irving J., 116 Livingston av., New Brunswick  
 Copleman, Benjamin, 263 High st., Perth Amboy  
 Copleman, H. B., 111 Livingston av., New Brunswick  
 Cottrell, Judson G., 159 Market st., Perth Amboy  
 Csema, Emery J., 151 Somerset st., New Brunswick  
 Degenhardt, Ira H., 51 Livingston av., New Brunswick  
 Dieker, Howard E., 351st Fd. Art., Cp. Livingst'n, La.  
 Downing, Perley E., Sedgwick av., Jamesburg  
 Duschock, Edward F., 188 Wash'g'n st., Perth Amboy  
 East, Isaac C., State Home for Boys, Jamesburg  
 Eulner, Elmer H., 216 Henry st., South Amboy  
 Fagan, James L., 51 Bayard st., New Brunswick  
 Fanelli, Antonio, 494 Compton av., Perth Amboy  
 Faulkingham, Ralph J., 61 Livingston av., New Brns.  
 Fazio, Vincent J., 353 Main st., South Amboy  
 Feher, Ladislav A. M., Camptown, Penna.  
 Fine, Hyman P., 151 Market st., Perth Amboy  
 Fine, Irvin J., 256 State st., Perth Amboy  
 Fishkoff, Alexander H., 132 Market st., Perth Amboy  
 Fithian, George W., 266 High st., Perth Amboy  
 Forney, Norman N., 96 N. Main st., Milltown  
 Forney, Norman N., Jr., 114 Van Lieu av., Milltown  
 Friedenthal, Bernard, Station Hosp., Ft. Bragg, N.C.  
 Gadek, Stanley A., Camp Forrest, Tenn.  
 Gauzza, Valentine P., 505 New Brunswick av., Fords  
 Gessner, Gerard R., Sta. Complement, Ft. Williams, Me.  
 Glasser, Benjamin F., 316 George st., New Brunswick  
 Goldberg, Harry C., 135 Market st., Perth Amboy  
 Goldberg, Isidore, 303 N. Washington av., Dunellen  
 Goldman, Solomon, 77 Livingston av., New Brunswick  
 Greenwood, Wm. R., 118 Somerset st., New Brunswick  
 Grieve, James, 88 Market st., Perth Amboy  
 Gurshman, Sol, 280 Amboy av., Metuchen  
 Gutowski, Jos. M., 433 Brace av., Perth Amboy  
 Haight, Harry W., 118 Raritan av., Highland Park  
 Hauber, Eugene A., 6 Quaid st., Sayreville  
 Haywood, Henry, 49 Paterson st., New Brunswick  
 Henry, Frank C., Jr., 214 Smith st., Perth Amboy  
 Hesseltine, Clair E., 269 Bordentown av., So. Amboy  
 Hilker, George F., 258 Maple st., Perth Amboy  
 Hinton, Samuel H., 123 Main st., Sayreville  
 Hofer, Clarence J. M., 463 Main st., Metuchen  
 Hoffman, Florentine M., 91 Bayard st., New Brunswick  
 Hoffman, Charles W., 261 Henry st., South Amboy  
 Hunt, Melvin M., 140 Jackson st., South River  
 Hutner, Cyril I., 134 Grove av., Woodbridge  
 Jablonski, John J., 100 Main st., Sayreville  
 Jacobson, Murray B., 138 Market st., Perth Amboy  
 Karshmer, Nathan, 92 Carroll pl., New Brunswick  
 Kelly, Leo J., 343 Barclay st., Perth Amboy  
 Kemeny, Imre, 48 Pulaski av., Carteret  
 Kleiber, Estelle E., 131 Livingston av., New Brunswick  
 Klein, Alexander, 215 High st., Perth Amboy  
 Klein, Edw. F., 136 Market st., Perth Amboy  
 Klein, William, 85 Bayard st., New Brunswick  
 Kler, Joseph H., 151 Livingston av., New Brunswick  
 Koelsch, Frederick J., 14 Kirkpatrick st., New Brunswick  
 Kohut, George J., 383 Lawrie st., Perth Amboy  
 Kovarsky, Albert E., 110 Market st., Perth Amboy  
 Krafchik, Louis L., 100 Bayard st., New Brunswick  
 Kramer, Samuel E., 254 State st., Perth Amboy  
 Lazow, S. Manlius, 199 Main st., Matavan  
 Leonard, George F., 63 N. 5th av., Highland Park  
 Levinson, Reubin, 241 State st., Perth Amboy  
 Lewis, Collins E., 293 Commercial av., New Brunswick  
 Lief, Lawrence H., Gatzmer av., Jamesburg  
 London, William, 255 State st., Perth Amboy  
 Long, Pauline A., 22 Livingston av., New Brunswick



Lund, John L., 267 High st., Perth Amboy  
MacDowall, John L., 113 Market st., Perth Amboy  
Mangogna, Philip, 334 Barclay st., Perth Amboy  
Mann, Jacob J., 255 State st., Perth Amboy  
Margaretten, Edward I., 263 High st., Perth Amboy  
Mark, Joseph S., 102 Green st., Woodbridge  
Marvin, Dorothy H., 51 Livingston av., New Bruns.  
Massey, J. Bruce, 20 Codwise av., New Brunswick  
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy  
McGovern, John F., Jr., 24 Liv'gst'n av.,N'wBr'ns'k  
McKiernan, Robt. L., 97 Bayard st., New Brunswick  
McKinstry, John W., Railroad av., Jamesburg  
Meacham, Eugene A., 112 N. Stevens av., So. Amboy  
Meinzer, Martin S., 147 Market st., Perth Amboy  
Merrill, Charles F., 16 S. 3rd av., Highland Park  
Miller, George M., 37th Div., Camp Shelby, Miss.  
Morris, Carlyle, 128 F. A., Fort Jackson, S. C.  
Nafey, Herbert W., 51 Livingston av., New Bruns'k  
Naulty, Chas. W., Jr., 403 High st., Perth Amboy  
Nieman, Solomon Z., 191 Livingston av., NewBruns.  
Normand, Alphonse F., 113 Market st., Perth Amboy  
O'Connell, James J., 116 Livingston av., NewBruns'k  
Panigrosso, Louis R., 455 Laurie st., Perth Amboy  
Pansy, Abraham A., 12 Jackson st., South River  
Pellicane, Anthony J., 183 Livingston av.,N'wBr'n'k  
Platt, Thomas H., 307 N. Washington av., Dunellen  
Reitman, Norman, 73 Livingston av., New Bruns'k  
Rineberg, Irving E., 137 Livingston av., New Bruns.  
Rona, Maurice, 10 Kirkpatrick st., New Brunswick  
Rothfuss, C. Howard, 574 Rahway av., Woodbridge  
Rothschild, Karl, 149 Livingston av., New Bruns'k  
Rowland, John H., 159 New st., New Brunswick  
Rubin, Benjamin, 193 Main st., South River  
Runyon, Laurance P., 80 Somerset st., NewBruns'k  
Sandella, Joseph F., 138 Livingston av.,NewBruns'k  
Saulsberry, Chas. E., 75 Livingston av., NewBruns'k  
Scott, Frederick W., 103 Bayard st., New Brunswick  
Witmer, John D., 456 Middlesex av., Metuchen  
Sender, Fannie, 193 Main st., South River  
Shayevitz, Abraham S., 102 Main st., South River  
Sherman, Wm. E., 88 Schureman st., New Bruns'w'k  
Shull, John V., 184 Kearny av., Perth Amboy  
Siegel, Isadore, 121 Market st., Perth Amboy  
Silk, Charles I., 236 High st., Perth Amboy  
Slobodien, Benjamin F., 233 High st., Perth Amboy  
Smith, Ivan B., Georges rd., Dayton  
Smith, John A., 106 Main st., South River  
Smith, John V., 463 State st., Perth Amboy  
Smith, Joseph A., Roosevelt Hospital, Metuchen  
Smith, Percy L., 16th Inf., Fort Devens, Mass.  
Smith, Sydney, 15 S. Third av., Highland Park  
Spencer, Ira T., 152 Main st., Woodbridge  
Spritzer, Theo. D., 102 S. Washington av., Dunellen  
Steffens, Charles T., 810 Madison av., Dunellen  
Stein, William, 177 Livingston av., New Brunswick  
Stephenson, Ruth, N. J. Col. for Women,NewBruns'k  
Sullivan, Chas. J., 57 Paterson st., New Brunswick  
Szuch, Nicholas, 159 Main st., South River  
Taber, Fred'k S., Hdqtrs., 3d Military Area, Newark  
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick  
Tucker, Sidney, 182 Market st., Perth Amboy  
Tyrrell, George W., 380 State st., Perth Amboy  
Uhr, Jacques S., 127 Livingston av., New Brunswick  
Ulan, Jerome, Main st., Spotswood  
Urbanski, Adrian X., 148 Market st., Perth Amboy  
Urbanski, Matthew F., 314Washington st.,P'hAmboy  
Van Dyke, Harry B., 501 Central av., Stelton  
Walker, Robert B., 108 Church st., New Brunswick  
Walters, George M., 158 Main st., Woodbridge  
Weber, John F., 264 Main st., South Amboy  
Weiner, Henry T., 111 Market st., Perth Amboy  
Wetterberg, Louis F., 74 Grove av., Woodbridge  
White, Harry J., Roosevelt Hospital, Metuchen  
Wiesenfeld, Benjamin, 472 Rahway av., Woodbridge  
Wilentz, Wm. C., 188 Market st., Perth Amboy

#### Number of Active Members and basis of representation, 157.

#### Associate Members

Barbano, Alfred J., WalterReedHosp.,W'sh'gt'n,D.C.  
Barnett, Lester A., 79 Booream av., Milltown  
Boyt, Theodore, 78 Main st., South River  
Cooperman, Eli L., 527 N. Brunswick av., Fords  
Gereben, Arpad G., 511 Rahway av., Woodbridge  
Gobel, Stanley J., 79 Talmadge av., Middlesex Boro  
Gorog, Nicholas M., 159 Bayard st., New Bruns'w'k  
Idelcowitz, Marie, 113 Washington st., So. River  
Lavine, Samuel C., 88 Livingston av.,NewBruns'w'k  
Lucey, James J., 184 Market st., Perth Amboy  
Walker, Otto, 72 Rahway ave., Woodbridge  
McLaughlin, Thomas F., 596 Main st., Metuchen  
Miller, S. David, 161 New st., New Brunswick  
Nelson, Axel R., 3042 Edmondsen av., Baltimore, Md.  
Richlin, Padie, 316 George st., New Brunswick  
Rubin, Wm., 362nd Infantry, Camp Claiborne, La.  
Salaky, Wm. L., 387 Neville st., Perth Amboy  
Schirber, Rene G., 11 Kirkpatrick st.,NewBruns'w'k  
Sokoloff, Oscar J., 67 Paterson st., New Brunswick  
Tisch, Leon, 5 Russell av., Piscatawaytown  
Vargyas, Joseph C., 116 New st., New Brunswick

#### Honorary Members

Henry, Frank C., Perth Amboy  
Van Dyke, Benjamin S., Cranbury

#### Transfers

Idelcowitz, Marie, from Essex County  
Landau, Maurice, to Rochester County, N. Y.  
Smith, Ivan B., from Hunterdon County  
Lavine, Samuel C., from Mercer County  
Mangogna, Philip, from Essex County

## MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

### Active Members

- Albright, Louis F., 118 Madison av., Spring Lake  
 Altschul, Frank J., 177 Garfield av., Long Branch  
 Baeseman, R. Winfield, 501 Grand av., Asbury Park  
 Baker, Elsworth F., N. J. State Hosp., Marlboro  
 Bar, Samuel, Kaplan's Resort, Jamesburg  
 Becker, Sidney D., 140 Maple pl., Keyport  
 Beveridge, Wm. W., 1000 Grand av., Asbury Park  
 Binder, Joseph, 101 Third av., Long Branch  
 Blaisdell, C. Byron, 489 Broadway, Long Branch  
 Bornstein, Paul K., 415 S. Lake drive, Belmar  
 Boyd, John B., 31 Oakland st., Red Bank  
 Brindle, Harry R., 501 Grand av., Asbury Park  
 Brown, Edith L., 332 Woodland av., Avon  
 Brown, Harvey S., 5 Club pl., Freehold  
 Brown, Kenneth G., 501 Grand av., Asbury Park  
 Bullwinkel, Fred'k, Ocean Blvd., Atlantic Highlands  
 Campbell, Wm. K., 96 Third av., Long Branch  
 Carey, David S., 11 E. Main st., Freehold  
 Carter, Joseph F. S., 142 Atkins av., Asbury Park  
 Captanian, Aram A., 154 Main st., Matawan  
 Ciampa, Ralph P. E., 383 Bath av., Long Branch  
 Clark, John C., 501 Grand av., Asbury Park  
 Colby, Maxwell X., 133 Chelsea av., Long Branch  
 Costa, Philip L., 88 East Front st., Red Bank  
 dePons, Sarah C., 501 Grand av., Asbury Park  
 DeVita, Anthony J., Wilson av., Port Monmouth  
 Dewis, Edwin G., 21 Westra st., Interlaken  
 Diamond, David I., Oceanport av., Oceanport  
 Duvall, Albert I., N. J. State Hospital, Marlboro  
 Edelson, Samuel, 1141 Corlies av., Neptune  
 Ellenson, Solomon S., 507 4th av., Asbury Park  
 Featherston, Daniel F., 506 4th av., Asbury Park  
 Feinberg, Harry D., 384 2nd av., Long Branch  
 Feldman, Joel, Rumson road, Rumson  
 Feman, J. George, 141 Main st., Keansburg  
 Fenton, Tennant E., 320 Ludlow av., Spring Lake  
 Fisher, James A., 501 Grand av., Asbury Park  
 Freedman, Harold H., 63 W. Main st., Freehold  
 Gesswein, Carl A., 35 Church st., Matawan  
 Glazer, Edward, 550 Cookman av., Asbury Park  
 Goff, Frank J., 64 Maple av., Red Bank  
 Gordon, J. Berkeley, N. J. State Hospital, Marlboro  
 Graves, Charles C., Jr., N. J. State Hosp., Marlboro  
 Guillum, Wm. H., 505 4th av., Asbury Park  
 Haines, Emerson S., 500 8th av., Asbury Park  
 Halbstein, Bernard M., 138 Bath av., Long Branch  
 Hancock, Michael Q., 705 D st., Belmar  
 Hardy, John W., 53 Main st., Farmingdale  
 Hausman, Samuel W., 50 W. Front st., Red Bank  
 Heatley, William, 23 Monmouth st., Red Bank  
 Herrman, Wm. G., 501 Grand av., Asbury Park  
 Heymann, Ernest, 345 Broad st., Red Bank  
 Hill, John A., 511 Cedar av., Allenhurst  
 Hindle, F. Lawton, 145 Maple av., Red Bank  
 Hodas, Sidney M., 158 Maple av., Red Bank  
 Holman, Francis W., 123 Broad st., Keyport  
 Holters, Otto R., 1002 Emory st., Asbury Park  
 Ingling, Harry W., 51 W. Main st., Freehold  
 Jamison, Wm. F., 501 Grand av., Asbury Park  
 Jones, Granville L., N. J. State Hospital, Marlboro  
 Jordan, Alexander D., 238 E. Main st., Manasquan  
 Jordan, Joseph C., Box A, Manasquan  
 Kanes, Edmund S., 406 Maple st., Columbia, S. C.  
 Kazmann, Harold A., 406 Broadway, Long Branch  
 Knapp, Victor, 505 Second av., Asbury Park  
 Krohn, Marc, Campbell av., Belford  
 Leighton, Robt. L., 401 Ludlow av., Spring Lake  
 Leonard, Lothair L., 615 Asbury av., Asbury Park  
 Levin, Jack, 8th Division, Fort Jackson, S. C.  
 Lewis, Jacob, 43 Court st., Freehold  
 Lorenzo, Michael J., 31 Oakland av., Red Bank  
 Lussier, Georges H., N. J. State Hospital, Marlboro  
 MacKenzie, Robt. A., 501 Grand av., Asbury Park  
 Maher, John E., 90 3rd av., Long Branch  
 Makin, John B., 501 Grand av., Asbury Park  
 Manahan, Daniel V., 55 E. Front st., Red Bank  
 Martin, Leonard J., 206 Prospect av., Asbury Park  
 Mason, Howard B., 90 W. Main st., Freehold  
 Matthews, William, 139 Broad st., Red Bank  
 McCreight, David W., ArmyAirBase, New Orleans, La.  
 McDonnell, George J., Medical Corps, Ft. Hancock  
 McKelvie, Julius C., 55 Rockwell av., Long Branch  
 McTague, Robert S., 88 3rd av., Atlantic Highlands  
 Metzger, Karl F., 401 5th av., Belmar  
 Miller, S. Thos., Dept. Radiology, U. of Pa., Phila., Pa.  
 Moffat, Barclay W., Nut Swamp rd., Red Bank  
 Mohair, John P., N. J. State Hospital, Marlboro  
 Murphy, Chas. M., 21 Main st., Farmingdale  
 Neiderhoffer, Sydney L., 469 Broadway, Long Branch  
 Nichols, Stanley H., 517 Broadway, Long Branch  
 Niemtzow, Frank, 55 E. Main st., Freehold  
 O'Mara, John A., 314 St. Clair av., Spring Lake  
 Osborn, A. Downey, 519 Sixth av., Belmar  
 Parker, James W., 175 Shrewsbury av., Red Bank  
 Parry, Oliver K., 601 Bangs av., Asbury Park  
 Pattenden, Franklin J., 300 2nd av., Asbury Park  
 Perrine, Cornelius C., 668 River rd., Fair Haven  
 Perrotta, Anthony J., 51st Signal Bn., Monroe, N. C.  
 Pieper, Howard C., Aviation Selection Bd., Chicago, Ill.  
 Pietri, Raoul, 501 Grand av., Asbury Park  
 Pleasants, Edward N., N. J. State Hosp., Marlboro  
 Podell, A. Alfred, 51 E. Front st., Red Bank  
 Pons, Carlos A., 501 Grand av., Asbury Park  
 Pregnall, James P., 501 Grand av., Asbury Park  
 Quirk, Martin A., 90 W. Front st., Red Bank  
 Raffetto, Joseph F., 550 Cookman av., Asbury Park  
 Reynolds, Donald G., 64 W. Main st., Freehold  
 Reynolds, George G., 64 W. Main st., Freehold  
 Robinson, Ernest A., 149 Atkins av., Asbury Park  
 Robinson, Wm. A., 62 Main av., Ocean Grove  
 Rowland, James J., 321 Bay av., Water Witch  
 Rubin, Adrian D., 401 1st av., Asbury Park  
 Rullman, Walter A., 58 W. Front st., Red Bank  
 Sacco, Gregory E., 191 Broad st., Red Bank  
 Sayre, William D., Box 202, Red Bank  
 Schlossbach, Theodore, Naval Air Sta., Lakehurst  
 Schmidt, Albert F., Naval Training Sta., Norfolk, Va.  
 Scott, Elmer A., Belle Mead San., Belle Mead  
 Sewell, Stephen, 320 Passaic av., Spring Lake  
 Shanik, William, 600 4th av., Asbury Park  
 Silverstein, Max, 605 1st av., Asbury Park  
 Slocum, Harry B., 263 Bath av., Long Branch  
 Stevenson, Geo. S., West Front st., Red Bank  
 Strahan, Frank G., 473 Broadway, Long Branch  
 Straughn, Clinton C., 23 Monmouth st., Red Bank  
 Strauss, Arthur, 130 Pavilion av., Long Branch  
 Thomas, Harry G., 1113 5th av., Asbury Park  
 Trippe, Clarence M., 702 Asbury av., Asbury Park  
 Upham, Helen F., 305 Third av., Asbury Park  
 Vaccaro, Sebastian P., 509 4th av., Asbury Park  
 Villapiano, Jos. G., 701 Sunset av., Asbury Park  
 Wainwright, Melvin A. R., 286 Broad st., Red Bank  
 Watkins, Robert E., 517 Fifth av., Belmar  
 Wilbur, Franklin L., 515 Eighth av., Asbury Park

Wilkins, Stanley O., 47 E. Front st., Red Bank

Wilson, Robert B., 91 Broad st., Red Bank

Woronoff, Murray, 120 Main st., Keyport

Wise, Lester D., 119 Morris av., Long Branch

Woodruff, Ralph G., Main st., Englishtown

**Number of Active Members and basis of representation, 139.**

**Associate Member**

Bases, Leonard, 204 Norwood av., Deal

**Honorary Member**

Ransohoff, Nicholas S., Long Branch

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**MORRIS COUNTY (14)**

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

**Active Members**

Ackermann, Edward, 5 Richards av., Dover  
Alcaro, Joseph A., 16 W. Blackwell st., Dover  
Baker, Augustus L., 389 W. Blackwell st., Dover  
Beaver, Jennie D., 44 Elm st., Morristown  
Bertha, Nicholas A., 301 S. Main st., Wharton  
Bird, Frank L., Main st., Netcong  
Blanchard, Charles L., 28 E. Blackwell st., Dover  
Bobadilla, Juan E. B., 2 Mercer st., Dover  
Booth, William K., 304 William st., Boonton  
Bowers, F. Clyde, Mountain av., Mendham  
Byrne, J. Arthur, 16 Elm st., Morristown  
Carberry, Edw. T., 83 S. Main st., Wharton  
Cohen, Oscar H., 115 Church st., Boonton  
Collins, Laurence M., N. J. State Hosp., Greystone Pk  
Comeau, Geo. W., 415 Speedwell av., Morris Plains  
Costello, William F., 55 W. Blackwell st., Dover  
Coults, Aldo B., 1 Madison av., Madison  
Crandell, Archie, N. J. State Hosp., Greystone Park  
Curry, Marcus A., N. J. State Hosp., Greystone Park  
Deichman, Charles H., 39 Elm st., Morristown  
DeRosa, Louis, Main av., Stirling  
Dochtermann, Warren P., 532 Main st., Chatham  
Donovan, Joseph, N. J. State Hosp., Greystone Park  
Earp, Ruth, 15 Olcott av., Bernardsville  
Eckhardt, Ralph A., 50 Green Village rd., Madison  
Emory, George B., Jr., 1 Franklin pl., Morristown  
Evans, Edgar J., Hinchman av., Denville  
Fagin, Joseph, 530 Morris av., Summit  
Failmezger, Theodore R., 125 Green av., Madison  
Falvello, Nicholas A., 28 Wetmore av., Morristown  
Ferriss, Ruth B., 51 Maple av., Morristown  
Forbes, John S., Jr., Cedar st., Basking Ridge  
Frost, Inglis F., 181 South st., Morristown  
Gambill, Perry J., N. J. State Hosp., Greystone Park  
Geary, Daniel J., 40 Maple av., Morristown  
Gibb, W. Blake, 26 Maple av., Morristown  
Gilbertson, Robert L., Pine Camp, N. Y.  
Glazebrook, Francis H., "Honeysuckle W'ds," Rumson  
Gordon, Charles D., Mt. Arlington  
Graddick, Lester W., 22 Sussex av., Morristown  
Gregory, Marie F., 50 Green Village rd., Madison  
Griscem, I. Norwood, 204 Church st., Boonton  
Hampton, Geo. R., N. J. State Hosp., Greystone Pk  
Harrington, J. Henry, 126 E. Main st., Rockaway  
Hatch, Harold S., Shonghum Sana., Morristown  
Haven, Samuel C., 14 Elm st., Morristown  
Hiler, Stuart A., 62 Rockaway av., Rockaway  
Hogan, Marshall D., 311 W. Main st., Boonton  
Hubert, Antonio O., 131 E. Main st., Rockaway  
Johnston, Julian F., 21 Van Doren av., Chatham

Judd, Wilbur M., N. J. State Hosp., Greystone Park  
Kessler, Edward I., N. J. State Hosp., Greystone Pk  
King, Alden P., 400 W. Blackwell st., Dover  
Kinkead, Hilda, 56 Prospect st., Madison  
Knowles, Frederick E., 103 Church st., Boonton  
Kossmann, Walter J., Long Valley  
Krauss, Fletcher I., 407 Main st., Chatham  
Kuite, George B., Station Hospital, Pine Camp, N.Y.  
Larson, Henry M., 35 Franklin st., Morristown  
Lasley, James M., N. J. State Hosp., Greystone Park  
Lathrope, George H., 965 Broad st., Newark  
Laudig, Guy H., 361 Speedwell av., Morris Plains  
Luippold, Eugene J., Jr., 318 Washington st., Boont'n  
Mathews, Raymond H., 186 South st., Morristown  
McElroy, Ervin, 20 Main st., Rockaway  
McMahon, Bernard C., 18 DeHart st., Morristown  
McMurray, Geo. B., N. J. State Hosp., Greystone Pk  
Michell, George E., 221 High st., Hackettstown  
Mills, Clifford, 36 Maple av., Morristown  
Monte, Thomas D., 16 Ledgewood av., Netcong  
Musetto, Carmelo A., 135 Cornelia st., Boonton  
Mutchler, Julia C., 153 E. Blackwell st., Dover  
Mutchler, H. Raymond, 153 E. Blackwell st., Dover  
Navazio, Attilio, 185 Speedwell av., Morristown  
Nicoll, George L., 25 MacDavitt pl., Dover  
Palazzo, William L., 135 Cornelia st., Boonton  
Parry, Allen A., 46 Green Village rd., Madison  
Parry, Antoinette R., 46 Green Village rd., Madison  
Pinckney, Frank H., 186 South st., Morristown  
Plume, Clarence A., Main st., Succasunna  
Pottinger, William E., 6 Altamont court, Morristown  
Prager, Bert A., 511 Main st., Chatham  
Rice, Franklin W., 184 South st., Morristown  
Riley, Philetus H., 26 Maple av., Morristown  
Rosenberg, Alvin A., 22 High st., Morristown  
Rubens, Otto, 27 E. Blackwell st., Dover  
Rubin, Henry S., 11 High st., Morristown  
Rubin, Samuel, 45 E. Blackwell st., Dover  
Ryman, Merlin T., 5 Dunbar st., Chatham  
Saltus, Lloyd S., 16 Elm st., Morristown  
Scott, Harold R., 10 Speedwell av., Morristown  
Seward, Frederic H., 40 Green Village rd., Madison  
Sherman, Benjamin, Aurora Institute, Morristown  
Sherman, Byron G., 52 Maple av., Morristown  
Smith, Malcolm K., 22 Madison av., Morristown  
Spencer, Alvan, 395 W. Blackwell st., Dover  
Stage, Earl DeW., 11 James st., Morristown  
Talmage, William G., Main st., Succasunna  
Taylor, Malcolm C., 181 South st., Morristown  
Teller, Daniel W., Jr., 28 DeHart st., Morristown



Terreri, D. Joseph, 30 High st., Morristown  
 Teskey, Stanley, 10 Anderson rd., Bernardsville  
 Thomas, Thomas S., Jr., 18 Elm st., Morristown  
 Thompson, Edna R., Main road, Flanders  
 Van Sickle, Albert W., Chester  
 von Deilen, Henry O., 28 DeHart st., Morristown  
 Voorhies, Wm. S., Jr., N. J. State Hosp., Gr'stone P'k  
 Voss, J. Landon, 21 Mt. Airy rd., Bernardsville  
 Zuck, John A., Main st., Netcong

Wade, Francis A., 196 South st., Morristown  
 Ward, Albert J., 39 Elm st., Morristown  
 Washburn, Philip C., N. J. State Hosp., Gr'stone P'k  
 Weiss, Herman, Aurora Institute, Morristown  
 Williams, David P., 284 Morris av., Mountain Lakes  
 Williams, Louis E., 80 Green av., Madison  
 Woodman, Charles B., 26 Maple av., Morristown  
 Young, George J., 60 Maple av., Morristown

#### Number of Active Members and basis of representation, 117.

#### Courtesy Members

Joy, Homer T., Morristown  
 Knight, Augustus S., Far Hills

Tidaback, John D., Summit  
 van Beuren, Frederick T., Jr., New York City

#### Honorary Members

Coults, Aldo B., Madison  
 Glazebrook, Francis H., Rumson

Haven, Samuel C., Morristown  
 Mills, Clifford, Morristown

Seward, Frederick H., Madison

### OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

#### Active Members

Appleton, Ralph, Lincoln av., Point Pleasant  
 Bierach, Jules L., Beach Haven Crest  
 Blumberg, A. William, New Egypt  
 Buermann, Robert, 206 Madison av., Lakewood  
 Bunnell, Frederick N., 22 S. Main st., Barnegat  
 Carmona, L. Roberto, 141 Wood st., Tuckerton  
 Dodd, Wm. E., Ocean st. & Bay av., Beach Haven  
 Falkenburg, LeRoy W., Atl'ntic C'y Blvd., Forked Riv'r  
 Frazee, Wm. H., Jr., Co. H, 119th Med. Reg., Ft. Dix  
 Gaumer, George W., 422 First st., Lakewood  
 Goldstein, Abraham, 404 Madison av., Lakewood  
 Graham, Rich'd B., Richm'd & Forman av., Pt. Pl's't  
 Green, Thomas J., New Egypt  
 Henriksen, J. Bruce, 422 River av., Point Pleasant  
 Herbener, Eugene G., 423 Third st., Lakewood  
 Hogan, James J., New Egypt

Ivory, Harry S., Phila. Naval Hosp., Philadelphia, Pa.  
 Joy, Ernest H., U. S. Naval Air Station, Lakehurst  
 Lehmacher, Frank, 16 Central av., Lakewood  
 Menge, Carl H., 236 Washington st., Toms River  
 Nyvall, Pierre J., Barnegat  
 Obert, J. Edwin, Main st., New Egypt  
 Pecora, Carmine L., Atlantic City Blvd., Beachwood  
 Sawyer, Blackwell, 109 Washington st., Toms River  
 Schneider, Clinton R., 125 N. Green st., Tuckerton  
 Sickel, Emanuel M., 318 Forest av., Lakewood  
 Szold, Norman F., 701 Princeton av., Lakewood  
 Taylor, Raymond A., 58 Madison av., Lakewood  
 Thompson, Theodore F., 316 First st., Lakewood  
 Tilles, Samuel, 44 Sheridan av., Seaside Heights  
 Towbin, Adolph, 326 Third st., Lakewood  
 Witte, C. Norman, 422 River av., Point Pleasant

#### Number of Active Members and basis of representation, 32.

#### Associate Members

Citta, J. Philip, Air Cps.Tr.Det., 188 Mulberry st., Nwk. Neiman, Watson E., Med. Det., 114th Inf., Ft. Dix  
 Smith, Edw. C., Med. Det., 127th Inf., Cp. Liv'gs'n, La.

#### Transfer

Graham, Richard B., from Essex County

## PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on second Thursday of each month except June, July, and August. Annual Meeting in May.

### Active Members

Ackerhalt, Martin J., 408 Clifton av., Clifton  
Allen, James M., 657 Main av., Passaic  
Alpren, Bernard F., 102nd Med. Reg., Ft. McClellan, Ala.  
Apter, Abraham H., 528 E. 29th st., Paterson  
Armstrong, Robt. R., 114 Pennington av., Passaic  
Ash, Frank W., 180 Carroll st., Paterson  
Atkinson, James W., 603 S. Maple av., Glen Rock  
Atwood, Edward A., 360 Park av., Paterson  
Averbach, Jacob, 435 Clifton av., Clifton  
Barlow, Frank A., 965 Madison av., Paterson  
Barolsky, Benj., 306 Broadway, Paterson  
Barr, Joseph, 975 Madison av., Paterson  
Baxt, Sidney J., 554 21st st., Paterson  
Becker, Frank F., 298 Diamond Br. av., Hawthorne  
Becker, George L., 646 E. 28th st., Paterson  
Becker, Leo V., 69 Ward st., Paterson  
Bender, Theo., 666 Broadway, Paterson  
Bergin, Joseph V., 315 Broadway, Paterson  
Berk, M. David, Station Hosp., Maxwell Field, Ala.  
Berkhout, Peter G., 106 Haledon av., Prospect Park  
Beshlian, Hagop K., 7 Lee pl., Paterson  
Biczak, Arkad K., 311 Lexington av., Clifton  
Blake, Albert J., 423 Broadway, Paterson  
Bohl, Louis J., 320 Broadway, Paterson  
Bongiorno, Henry D., 516 River st., Paterson  
Bonyne, Henry A., 123 Prospect st., Ridgewood  
Bornstein, David, 80 Carroll st., Paterson  
Botbyl, Burt W., 927 Madison av., Paterson  
Boylan, Lawrence B., 630 Main st., Paterson  
Brancato, Peter, 17 Church st., Paterson  
Brogan, Francis B., Station Hosp., Cp. Blanding, Fla.  
Bromberg, Chas. B., 107 Lexington av., Passaic  
Brooks, Sidney S., 380 12th av., Paterson  
Budd, J. Reuben, 379 Clifton av., Clifton  
Bullen, Victor E., 148 Hamilton av., Paterson  
Butterfield, Arey A., 135 Ayerig av., Passaic  
Calligaro, Egildo A., 75 Clifton av., Clifton  
Capell, Harry H., 87 Bridge st., Paterson  
Carlisle, John H., 129 Prospect st., Passaic  
Carlough, David J., 426 Ellison st., Paterson  
Catanzaro, Francesco, 151 Jefferson st., Passaic  
Chapman, Walter L. Jr., 944 Boulevard, Bayonne  
Chapnick, Maurice M., 117 Paterson st., Paterson  
Charney, William, 647 Broadway, Paterson  
Cherry, Homer H., Valley View Sana., Paterson  
Chester, Saul W., 634 Broadway, Paterson  
Chilton, Forrest S., Newark-Pmptn.Tpk., Pmptn.Pl'ns  
Chrisman, Irving, 423 Broadway, Paterson  
Ciccione, Anthony C., 389 Grand st., Paterson  
Clark, Orlo H., 149 Prospect st., Passaic  
Clay, Thomas A., 351 Totowa av., Paterson  
Close, Byron H., Hamburg Trnpg., Bloomingdale  
Cogan, Henry, P. O. Box 3364, Daytona, Florida  
Cohen, Julian, 475 Park av., Paterson  
Cohen, Louis, 257 Paulison av., Passaic  
Cohen, M. Marvin, 137 Graham av., Paterson  
Cohn, Isidor, 231 Lexington av., Passaic  
Cole, L. Frank, 242 Broadway, Passaic  
Connolly, Joseph P., 64 Hamilton st., Paterson  
Connolly, T. Vincent, 56 Hamilton st., Paterson  
Conserva, Peter V., 215 Dayton av., Clifton  
Cortese, Alvin E., 26 Ward st., Paterson  
Cotton, Norman T., 219 Graham av., Paterson  
Cremens, John F., 144 Carroll st., Paterson  
Crescente, Fred J., 827 Madison av., Paterson  
Crounse, David R., 84 Broadway, Passaic  
Curtis, A. Maurice, 445 Van Houten st., Paterson  
Davis, A. Hobson, Paterson Gen. Hosp., Paterson  
Dawson, Harry, 618 E. 24th st., Paterson  
DeBell, Peter J., 65 Summer st., Passaic  
DeGrace, Francis H., 344 Gregory av., Passaic  
Deich, Samuel R., 162 Lexington av., Passaic  
Delario, Anthony J., 294 Broadway, Paterson  
Del Mauro, Alphonse, 460 Park av., Paterson  
DeMattia, Michael, 71 Ward st., Paterson  
De Rosa, Armand, 262 Totowa rd., Totowa  
De Rosa, John, 281 East 30th st., Paterson  
Desmet, Victor F., 324 Broadway, Paterson  
De Yoe, Leon E., 602 Broadway, Paterson  
Dingman, Norman M., 330 Broadway, Paterson  
Doktor, David, 288 Hamilton av., Paterson  
Donnelly, Joseph E., 445 Market st., Paterson  
Douglass, Stephen A., Valley View Sana., Paterson  
Dow, Robt. F., 592 East 29th st., Paterson  
Drake, Daniel E., Union Valley rd., Newfoundland  
Duncan, Owsley B., 654 East 28th st., Paterson  
Dunning, Walter L., 533 River st., Paterson  
Dwyer, Henry E., 261 Madison st., Passaic  
Dwyer, William A., 99 Park av., Paterson  
Edlkraut, Edward C., 129 Highland av., Passaic  
Ehrenfeld, Edward, 185 Lexington av., Passaic  
Ehrenfeld, Irving, 185 Lexington av., Passaic  
Ekins, Frank P., 221 Broadway, Paterson  
Esposito, Anthony L., 478 Clifton av., Clifton  
Farkas, Gustav, 95 Jackson st., Passaic  
Fenster, Morton N., 211 Lexington av., Passaic  
Ferrary, Paul B., 232 Totowa rd., Totowa Boro  
Fiering, Abraham M., Pompton Tnpg., M'tain View  
Fishbein, Elliot, 70 Carroll st., Paterson  
Fisher, Samuel, 808 Madison av., Paterson  
Flitcroft, William, 510 River st., Paterson  
Fortuin, Floyd, 292 Broadway, Paterson  
Freedman, Jacob S., 223 Lexington av., Passaic  
Gallardo, Agustin, 61 Lakeside av., Pompton Lakes  
Gallo, James S., 594 Broadway, Paterson  
Geiger, Harold C., Main st., West Milford  
Gelman, Sidney, 579 Broadway, Paterson  
Giambra, Sante M., 666 Broadway, Paterson  
Gillson, Hugh V., 21 Lee pl., Paterson  
Ginsburg, Samuel, 227 Paulison av., Passaic  
Gladstone, Sidney A., Barnert Mem. Hosp., Paterson  
Glasgow, Thomas M., 120 Passaic av., Passaic  
Gochman, Harry M., 166 Hamilton av., Paterson  
Goldenberg, Raphael R., 588 E. 27th st., Paterson  
Golding, Harry N., 180 Carroll st., Paterson  
Gordon, Abel, 616 Main av., Passaic  
Gordon, Samuel, 515 Broadway, Paterson  
Gormley, Cyrus M., 15 Kiel av., Butler  
Gould, John H., 263 Franklin av., Ridgewood  
Graeter, F. Albert, 265 Gregory av., Passaic  
Graham, Archibald F., 42 Park av., Paterson  
Graham, Theodore K., 279 Park av., Paterson  
Greengrass, Jacob J., 146 Broadway, Paterson  
Grosfeld, William, Valley View Sanatorium, Paterson  
Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne  
Hagen, Orville R., 292 Broadway, Paterson  
Hall, Wayne W., 360 Park av., Paterson  
Halnan, John J. Jr., 631 Madison av., Paterson  
Hambright, Arthur M., Wyckoff av., Ramsey  
Harreys, Chas. W., 153 Prospect st., Ridgewood  
Hattem, Elias J., 1046 Main st., Paterson  
Hayman, Irving R., 681 Broadway, Paterson  
Hillmann, Frederick C., 64 Hamilton st., Paterson  
Hollingsworth, H. Hale, 86 First st., Clifton  
Holmes, Thomas J. E., 151 Fair st., Paterson  
Holt, Herman H., 256 Graham av., Paterson

- Hughes, J. Vernon, 655 Main av., Passaic  
 Ianacone, John A., 310 Fifth av., Paterson  
 Iraggi, James V., 158 Gregory av., Passaic  
 Izenberg, David, 555 E. 29th st., Paterson  
 Jackson, Dominic P. D., 13 Center av., Little Falls  
 Jaffe, Hyman, 149 Broadway, Passaic  
 Jahn, Albert G., 657 Main av., Passaic  
 Jani, Frank F., 297 Lexington av., Passaic  
 Jarmulowsky, Harry, 181 E. 33rd st., Paterson  
 Jehl, Joseph R., 305 Clifton av., Clifton  
 Joelson, Dora, 485 Park av., Paterson  
 Joelson, Morris S., 577 Broadway, Paterson  
 Joffe, Philip M., 556 E. 28th st., Paterson  
 Joffe, Sidney H., 556 E. 28th st., Paterson  
 Johnsen, Sigurd W., 149 Prospect st., Passaic  
 Joseph, Morris, 271 Lexington av., Passaic  
 Joyce, Leo H., 259 Madison st., Passaic  
 Keating, Charles A., 177 Ellison st., Paterson  
 Keating, Joseph M., 275 Passaic av., Passaic  
 Keller, Michael L., 673 East 27th st., Paterson  
 Kennedy, A. Andrew, Phila. Naval Hosp., Phila., Pa.  
 Kennedy, Eugene T., 413 Wanaque av., Pmptn. Lks.  
 Keppler, Charles, Jr., 723 Allwood rd., Clifton  
 Kim, Gay B., 703 Main st., Paterson  
 Kinney, Burton O., 41 Lincoln av., Little Falls  
 Kleiner, Samuel, 162 Hamilton av., Paterson  
 Koenig, Bertram, 306 Broadway, Paterson  
 Koerber, George, 136 Prospect st., Passaic  
 Kovaleski, Walter A., 77 Market st., Passaic  
 Kovic, Abraham, 123 Lexington av., Passaic  
 Krieger, George, 269 Broadway, Passaic  
 Kroll, Adolph, Jr., 103 Van Buren st., Passaic  
 Kuhl, John P., 38 Main st., Butler  
 Laauwe, Harold W., 198 Haledon av., Prospect Park  
 Labash, Charles S., 83 Quincy st., Passaic  
 Landaw, Louis, 631 E. 26th st., Paterson  
 Lawrence, Arthur C., Main st., Box 21, Lincoln Park  
 Lawrence, Elias D., 365 Union av., Paterson  
 Leach, John E., 372 Park av., Paterson  
 Lee, Frederick P., 606 E. 27th st., Paterson  
 Leibovitz, Altan C., 261 Lexington av., Passaic  
 Lemay, Albert T., 532 14th av., Paterson  
 Levendusky, Daniel E., 52 Market st., Passaic  
 LeVine, Israel, 215 Broadway, Paterson  
 Levine, David B., 647 Broadway, Paterson  
 Levine, Sidney C., 459 Park av., Paterson  
 Levinsohn, Sandor A., 636 East 29th st., Paterson  
 Levy, Herman, 219 Lexington av., Passaic  
 Liana, Stephen M., 771 Madison av., Paterson  
 Linares, A. Carfi, 208 Market st., Paterson  
 Lipton, Louis, 67 Passaic av., Passaic  
 Lobsenz, Nathan P., 294 Broadway, Paterson  
 Lomauro, James R., 184 Lexington av., Passaic  
 London, Jules R., 153 Jefferson st., Passaic  
 Low, Donald B., 529 Broadway, Paterson  
 Lucent, S. Bell, 2 First av., Little Falls  
 Luksteid, Casimir J., 326 Park av., Paterson  
 MacAlister, Wm. W., 171 Carroll st., Paterson  
 MacGregor, Allan W., 379 Ellison st., Paterson  
 MacGuffie, Robert N., 657 Main av., Passaic  
 Mackler, Meyer E., 575 Broadway, Paterson  
 Maclay, Joseph A., 239 Broadway, Paterson  
 Maffongelli, Joseph A., 494 River st., Paterson  
 Magnes, Max, 2d Cost Artillery, Ft. Hamilton, N. Y.  
 Manly, Thomas E., 390 Park av., Paterson  
 Manzione, Frank A., 500 Union av., Paterson  
 Maps, Howard L., 53 Passaic av., Passaic  
 Marini, Dominick, 40 Henry st., Passaic  
 Markel, Albert G., 450 Park av., Paterson  
 Markowitz, Louis, 380 Park av., Paterson  
 Marrocco, William A., 88 Vreeland av., Paterson  
 Marsh, Elias J., 400 Van Houten st., Paterson  
 Martin, Theodore, 577 Lincoln av., Glen Rock  
 Masucci, Alberico, 128 Carroll st., Paterson  
 Matthews, Leonard M., 655 Main av., Passaic  
 McBride, Andrew F., 30 Church st., Paterson  
 McBride, Andrew F., Jr., 655 Broadway, Paterson  
 McCamey, Kenneth E., 612 E. 29th st., Paterson  
 McCarthy, George L., 506 Union av., Paterson  
 McCue, John B., 912 Lincoln av., Pompton Lakes  
 McDede, Frank F., 922 Main st., Paterson  
 McDonald, Richard J., 80 Park av., Paterson  
 McPherson, Malcolm E., 141 Diam'd Br. av., H'wth'rne  
 Meier, William U., 1062 Ringwood av., Haskell  
 Meloney, Lester F., 156 Second st., Clifton  
 Mendelsohn, David H., 576 Broadway, Paterson  
 Meneve, Alfred D., 373 Broadway, Paterson  
 Meyers, Francis R., U. S. Naval Air Sta., Miami, Fla.  
 Michela, Luigi S., 206 Carroll st., Paterson  
 Michelson, Henry, 258 Park av., Paterson  
 Missonellie, Wm., 404 Lafayette av., Hawthorne  
 Mitchell, Charles R., 311 Broadway, Paterson  
 Monaloy, Morris A., 24 Day st., Clifton  
 Morici, Theodore, 80 Howe av., Passaic  
 Moscoe, Harry A., 707 Broadway, Paterson  
 Mott, Joseph E., 426 Park av., Paterson  
 Murn, Charles J., 48 Smith st., Paterson  
 Neer, William, 245 Broadway, Paterson  
 Nemirow, Martin, 234 Lexington av., Passaic  
 Nesbitt, Elizabeth, No. Jersey Tr'n'g Sch'l., Little Falls  
 Norval, William A., 419 Main st., Paterson  
 Notkin, Meyer, 559 Broadway, Paterson  
 Noto, Philip, 158 Washington pl., Passaic  
 Nye, Howard H., 174 Carroll st., Paterson  
 O'Brian, Dennis M., 154 Lexington av., Passaic  
 Ogden, Michael A., Passaic General Hosp., Passaic  
 Okin, Irving, 165 Passaic av., Passaic  
 Oppen, Philip, 606 E. 26th st., Paterson  
 Oram, Joseph H., 495 Broadway, Paterson  
 Pal, Darbari R., 32 Clark st., Paterson  
 Palma, Nicholas, 116 17th av., Paterson  
 Palmer, Francis R., 220 Lexington av., Passaic  
 Paris, Wm., 1st Engineer Bat., Fort Devens, Mass.  
 Park, M. Benjamin, 360 Park av., Paterson  
 Patella, Fulvio, 324 Broadway, Paterson  
 Perneti, Anthony M., 320 Broadway, Paterson  
 Phelps, James E., 203 Park av., Paterson  
 Piasecki, Chester A., 741 E. 23rd st., Paterson  
 Piller, Jacob, 213 Broadway, Paterson  
 Pink, Solomon H., 21 High st., Butler  
 Plinke, Fritz W., 159 Lexington av., Passaic  
 Polizzotti, Joseph L., 193 Park av., Paterson  
 Polowe, David, 555 E. 27th st., Paterson  
 Prince, Robert A., 567 Broadway, Paterson  
 Provisor, Benjamin, 112 Lexington av., Passaic  
 Raab, Michael, 250 Lexington av., Passaic  
 Randazzo, Anton P., 82 Prospect st., Passaic  
 Rauschenbach, Paul E., 225 Broadway, Paterson  
 Rauschenbach, P.E., Jr., 112th Med. Rg., Cp. Shelby, Miss.  
 Reading, H. Eugene, 535 E. 29th st., Paterson  
 Reeves, Ernest, 195 Lexington av., Passaic  
 Reilly, Thomas F., 127 Union av., Clifton  
 Reinhorn, Abraham J., 302 Broadway, Paterson  
 Reynolds, Harry C., 657 Main av., Passaic  
 Riccobono, Cosmo S., 334 Park av., Paterson  
 Richards, Paul S., 1 Main st., Butler  
 Rinzer, Harry G., 127 Van Houten av., Passaic  
 Roemer, Jacob, 591 E. 27th st., Paterson  
 Ross, Peter W., 655 Main av., Passaic  
 Rothman, Theodore, 494 Park av., Paterson  
 Roy, Jos. N., 95 17th av., Paterson  
 RuBacky, Joseph F. A., 57 Passaic av., Passaic  
 Ruocco, William B., 416 River st., Paterson  
 Russell, Charles B., 119 Hamilton av., Paterson  
 Sabarese, Theodore C., 122 Marsellus pl., Garfield  
 Saffron, Morris H., 292 Paulson av., Passaic  
 Sala, Aldo W., 172 Randolph av., Clifton  
 Salzman, Nathan, 714 Broadway, Paterson  
 Sanfacon, Thomas A., 340 Park av., Paterson  
 Santangelo, Emil L., 349 Broadway, Paterson



Schafer, Marguerite A., 298D'mondBr. av., H'wth'rne  
Scheffrin, Alexander E., 235 Lexington av., Passaic  
Schlossberg, Ezra, 178 Sherman st., Passaic  
Schubert, Roy R., 466 Park av., Paterson  
Schultz, Augustin M., 379 Union av., Paterson  
Schwartz, Jacob R., 8-04 Fairlawn av., Fair Lawn  
Schwartz, William, 224 Lexington av., Passaic  
Schwartzberg, Frederick I., 522 Broadway, Paterson  
Scielzo, Nicholas F., 369 Park av., Paterson  
Scribner, Chas. H., R.F.D.1, Hamb'gTnpk., Preakness  
Shapiro, Louis G., 375 Broadway, Paterson  
Shechtman, Abraham, 261 Main av., Passaic  
Sheft, Matthew J., 36th Eng. Bn., Plattsburgh, N. Y.  
Shinefeld, Maurice A., 669 Broadway, Paterson  
Shipman, Meyer P., 185 E. 33rd st., Paterson  
Shippee, James N., 654 Ringwood av., Wanaque  
Shulman, Abraham, 528 E. 29th st., Paterson  
Silverman, Irving A., 260 Dayton av., Clifton  
Simkin, Abraham, 247 Broadway, Passaic  
Simon, Julius J., 174 Columbia av., Passaic  
Simon, Morris L., 174 Washington pl., Passaic  
Siveke, John, 106 Lexington av., Passaic  
Slaff, Florence, 16 Grove st., Passaic  
Sloan, Samuel L., 182 Belmont av., Paterson  
Small, Louis, 23 Passaic av., Passaic  
Smith, Elroy W., 655 Main av., Passaic  
Smith, Leon A., 655 Main av., Passaic  
Sobel, I. Jerome, 136 Broadway, Passaic  
Spickers, William, 6 Church st., Paterson  
Stark, Jacob, 645 Broadway, Paterson  
Stein, Harold M., 227 W. Broadway, Paterson  
Steinberg, Benjamin L., 543 Main st., Singac  
Stern, Morris H., 709 Main av., Clifton  
Stinson, Richard, 641 E. 18th st., Paterson  
Stokes, James S., 85 Park av., Paterson  
Stolz, Raymond R., 23 Passaic av., Passaic  
Sucoff, Moses C., 158 Hamilton av., Passaic  
Sullivan, William M., Jr., 43 Passaic av., Passaic  
Surgent, George W., 168 Clifton av., Clifton  
Sutherland, William W., 400 Broadway, Paterson  
Szymanski, John J., 616 Main av., Passaic  
Taber, Leslie R., 292 Broadway, Paterson  
Teichholz, Max. H., 164 Hamilton av., Passaic  
Tell, M. Edward, 249 Lexington av., Passaic  
Tellman, Daniel H., 120 Lexington av., Passaic  
Temple, Arthur H., 164 Jefferson st., Passaic  
Terhune, Percy H., 81 Millbrook rd., Hamden, Conn.  
Thomas, Irene O., 350 Lafayette av., Hawthorne

Thompson, Edward C., 373 Park av., Paterson  
Thorne, William P., 254 Main st., Butler  
Thron, Leopold E., 586 E. 29th st., Paterson  
Todd, Francis H., 83 Auburn st., Paterson  
Tomkins, William, 105 Fairmount road, Ridgewood  
Tuers, George E., 418 Park av., Paterson  
Tweddel, George K., 239 Broadway, Paterson  
Udinsky, Hyman J., 21 Grove st., Passaic  
Vanderbeck, James J., 281 Park av., Paterson  
Vanderbeek, Andrew B., 174 Broadway, Paterson  
Vanderbeek, Frank B., 407 Park av., Paterson  
Vander Clock, Cornelius, 23 Passaic av., Passaic  
Van Eerde, Albert, 339 Lafayette av., Hawthorne  
Van Riper, A. Ward, 605 Main av., Passaic  
Van Schott, Gerard J., Jr., 245 Lex'gton av., Passaic  
Van Urk, Frederick T., 442 Lexington av., Clifton  
Van Winkle, John S., 297 Broadway, Paterson  
Vermeulen, Abram, 344 Haledon av., Prospect Park  
Visceglia, Frank R., 99 Gregory av., Passaic  
Vosburgh, Fred, 61 Passaic av., Passaic  
Vreeland, Ralph J., 266 Van Houten st., Paterson  
Walker, Harold G., Everett av., Wyckoff  
Wallace, Marc J., 165 Lakeview av., Clifton  
Walton, Gordon G., 17 Church st., Paterson  
Warburton, Jack C., 333 Park av., Paterson  
Warren, David E., 154 Broadway, Passaic  
Warren, Earl L., 266 Van Houten st., Paterson  
Warren, Jacob, 308 18th av., Paterson  
Wassing, Hans, 695 Broadway, Paterson  
Weinert, Henry V., 128 Market st., Passaic  
Weintraub, Wm. L., 400 Broadway, Paterson  
Weisman, Stephen L., 566 Broadway, Paterson  
Westerhoff, Peter D., 51 Highland av., MidlandPark  
Wethers, William A., 171 Market st., Passaic  
White, Richard E., 303 Crooks av., Paterson  
Williams, Hiram, 230 Lexington av., Passaic  
Winters, Walter M., 288 Broadway, Paterson  
Wishnack, Meyer, 318 Broadway, Paterson  
Wolf, Erich, 158 Broadway, Passaic  
Wolf, Israel J., 231 East 31st st., Paterson  
Wolfson, Harry, 356 Park av., Paterson  
Wry, Dean A., 234 Dayton av., Clifton  
Yachnin, Samuel C., Station Hospital, Fort Dix  
Yager, J. Allen, 420 Broadway, Paterson  
Yates, John S., 414 Ellison st., Paterson  
Yolken, Harry, 246 E. 31st st., Paterson  
Zalewski, Irene J., 125 Market st., Passaic  
Zuckerman, David E., 345 Broadway, Paterson

#### Number of Active Members and basis of representation, 382.

#### Associate Members

Asten, George, 220 Belmont av., Haledon  
Chudzik, Edward W., 541 Page av., Lyndhurst  
Feliciano, Vincent, 33 N. 8th st., Hawthorne  
Fenwick, John R., 102 Vreeland av., Clifton  
Goldman, Sol, 715 Broadway, Paterson  
Kaletkowski, Marion F., 100 Hope av., Passaic

Klughaupt, Dorothy K., 49 Passaic av., Passaic  
Lima, John G., 292 Broadway, Passaic  
Nussbaum, Nathan, 122 E. 33rd st., Paterson  
Pollock, Theodore, 472 Clifton av., Clifton  
Schwarz, Julianna L., 255 Harrison st., Passaic  
Yeaw, Ralph C., 180 Carroll st., Paterson

#### Courtesy Members

Della Penna, Samuel J., Bergenfield  
Pellitteri, Ottavio J., Warren Point  
Pearlman, Saul J., Passaic

#### Resigned

Siniscal, Arthur A., Passaic

#### Transfer

Jackson, D. P. D., from Warren County

**SALEM COUNTY (17)**

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

**Active Members**

Bramble, Halsey S., Front & Chestnut sts., Elmer  
Caggiano, John D., 165 W. Main st., Penns Grove  
Chesler, Maurice, 124 W. Broadway, Salem  
Church, Franklin W., 86 W. Broadway, Salem  
Cox, J. Robert, 37 W. Main st., Penns Grove  
Davison, C. Spencer, 7 Chestnut st., Salem  
Davison, Wilbur S., 13 N. Broadway, Pennsville  
Dunn, John S., 75 Market st., Salem  
Eisemann, Jerome S., 157 W. Broadway, Salem  
Evans, Edgar E., 12 Ziegler Tract, Penns Grove  
Fleming, Charles L., 42 W. Main st., Penns Grove  
Green, David W., 69 Market st., Salem  
Hilliard, William T., 105 Market st., Salem  
Hummel, Lee C., 109 W. Broadway, Salem  
Jirouch, Edwin A., 18 Ziegler Tract, Penns Grove

Lipkin, Isadore, 157 W. Main st., Penns Grove  
Lummis, Clarence P., 40 Delaware av., Penns Grove  
Mackes, Claude B., 48 N. Main st., Woodstown  
Miller, Lewis H., 37 S. Main st., Woodstown  
Miller, William H., 33 S. Main st., Woodstown  
Perry, Frank L., 39 East av., Woodstown  
Prigger, Edward R., 39 W. Main st., Penns Grove  
Savage, Charles L., 20 Ziegler Tract, Penns Grove  
Sayers, Francis P., 37 W. Main st., Penns Grove  
Silverman, R. Louis, 21 W. Main st., Penns Grove  
Suter, Harry F., 49 W. Main st., Penns Grove  
Sutherland, Robert C., 95 S. Broad st., Penns Grove  
Thomas, Claude W., 28 East av., Woodstown  
Weigel, Charles F. B., 411 Liberty st., Erie, Pa.  
Zappala, John, 47 W. Main st., Penns Grove

Number of Active Members and basis of representation, 30.

**Honorary Member**

James, William H., Pennsville

**Transfers**

Norwood, William D., to Indiana

Savage, Charles L., from Virginia

Sayers, Francis P., from Pennsylvania

**SOMERSET COUNTY (18)**

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

**Active Members**

Adams, Rayford K., Lakeside Lodge, Skillman  
Albrecht, William J., 25 N. Bridge st., Somerville  
Allegrante, Anthony J., W'sh'gt'n Val.rd., Martinsville  
Ambrose, Robert R., 125 Hamilton st., Bound Brook  
Barbour, George E., 115 W. High st., Somerville  
Bendix, Gerhard M., 80 West End av., Somerville  
Blank, Samuel, N. J. State Village, Skillman  
Borow, Benjamin, 507 Church st., Bound Brook  
Borow, Henry, 507 Church st., Bound Brook  
Borow, Louis S., 507 Church st., Bound Brook  
Borow, Maurice, 507 Church st., Bound Brook  
Brittain, Elmore G., 4 E. High st., Bound Brook  
Cooley, Justin H., 3 W. Union av., Bound Brook  
Cooper, J. Howard, East Millstone  
Craig, Henry A., 315 William st., Somerville  
Crawford, John W., Main st., Bedminster  
Day, Hayward F., 37 Craig pl., N. Plainfield  
Douglas, William C., 15 Olcott av., Bernardsville  
Edelberg, Sidney S., 403 E. High st., Bound Brook  
Ely, Lancelot, 128 W. High st., Somerville  
Falcone, Nicholas A., 68 Watchung av., N. Plainfield  
Field, Frank L., Far Hills  
Flint, Edgar T., 44 E. Somerset st., Raritan  
Flynn, Thomas H., 41 W. High st., Somerville  
Fritts, Lewis C., West End av., Somerville  
Galgoczy, Julius, Manville  
Gray, W. Burritt, 121 Somerset st., N. Plainfield  
Greenberg, George A., 195 W. High st., Somerville  
Guertin, Diomede, N. J. State Village, Skillman  
Hamblin, Donald O., Calco Chemical Co., Bound Br'k

Heaton, Stuart C., Calco Chemical Co., Bound Br'k  
Hegeman, Runkle F., 161 W. High st., Somerville  
Heminway, Norman L., Ft. Preble, Portland, Me.  
Hird, Emerson F., 118 E. Maple av., Bound Brook  
Hochheimer, Arthur, 211 Hamilton st., Bound Br'k  
Husted, Samuel H., Neshanic Station  
Kay, Clarence R., Main st., Peapack  
Klompus, Irving, 403 E. High st., Bound Brook  
Knight, Augustus S., Far Hills  
Lawton, A. Anderson, 15 N. Bridge st., Somerville  
Levy, Abram, 1120 W. 7th st., Plainfield  
Liddell, Raymond N., 150 W. High st., Somerville  
Loeb, William A., Veterans' Adm., Lyons  
Lovejoy, James L., 224 Somerset st., Bound Brook  
Mangelsdorff, Arthur F., Calco Chem. Co., B'd Brook  
McConaughy, Francis, 1 E. High st., Somerville  
Morris, Nathan, 40 Grove st., North Plainfield  
Pearson, Theodore A., White House  
Pieper, Ernest E., Veterans' Adm., Lyons  
Pigott, Albert W., N. J. State Village, Skillman  
Pitman, Mason W. H., 17 W. Cliff st., Somerville  
Pogoloff, Samuel H., 68 N. 1st av., Manville  
Reale, Frank P., Brook's Blvd., Manville  
Reale, Nicholas P., Brook's Blvd., Manville  
Renner, Clara C., N. J. State Village, Skillman  
Robinson, John T., 598 Watchung rd., Bound Brook  
Rossi, Gene, 79 Talmage av., Bound Brook  
Russo, Dominic T., 51 E. Somerset st., Raritan  
Sargent, Eva R., 22 Sycamore st., Somerville  
Schram, William S., 252 Bergen av., Kearny

Smalley, Mahlon C., Gladstone  
Spaldo, John L., 15 N. Bridge st., Somerville  
Thornton, P. John S., Veterans' Administration, Lyons  
Tolomeo, Martin E., 5 E. High st., Bound Brook  
Wallach, Bernard, 74 Watchung av., No. Plainfield  
Wild, Frederick A., 111 E. High st., Bound Brook  
Young, James L., 68 Mountain av., Somerville

Number of Active Members and basis of representation, 67.

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## SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets at call of President. Annual Meeting on second Tuesday in May.

### Active Members

Aitken, Herbert M., Ogdensburg  
Bergmann, Ewald H., 44 Bank st., Sussex  
Braun, David C., 216 Spring st., Newton  
Burn, Victor E., 27 Trinity st., Newton  
Caleca, Jack J., Andover  
Coleman, Joseph G., Hamburg  
Drake, Leo B., 47 Main st., Franklin  
Eddy, Lester R., 40 Bank st., Sussex  
Groeschel, August H., 31 Bank st., Sussex  
Hill, Dean F., Sussex  
Johnson, George F., Branchville  
Kirschner, Martin I., Vernon  
Landes, Edwin W., Stillwater

Longnecker, John E., Jr., Sparta  
Loux, Henry A., 40 Main st., Sussex  
Lushear, Frank H., Branchville  
McCall, Jesse, 9 Linwood av., Newton  
McVeigh, Charles J. D., Netcong  
Morrison, Frederick H., 61 High st., Newton  
Pellett, Thomas L., Hamburg  
Roy, Bert W., 25 Hamburg av., Sussex  
Schmidt, Clifford M., 81 Main st., Newton  
Scott, Frederick J., 1 Oak st., Franklin  
Smith, Warren H., 91 Main st., Newton  
Spencer, James H., Jr., 23 Hospital rd., Franklin  
Spurgeon, Dorsett L., 19 Church st., Newton

Number of Active Members and basis of representation, 26.

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## UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May.  
Annual Meeting in April.

### Active Members

Abel, Henri E., 339 Union av., Elizabeth  
Abramson, Solomon, 1587 Irving st., Rahway  
Ackerman, Arthur F., 129 Summit av., Summit  
Anson, Leon J., 314 Center st., Garwood  
Armstrong, Lorrimer B., 121 S. Euclid av., Westfield  
Arthur, Frances H., 138 Westfield av., Elizabeth  
Austin, Thomas R., 19 Holly st., Cranford  
Babbitt, Hugh M., Jr., 950 Park av., Plainfield  
Baker, Raymond D., 52 De Forest av., Summit  
Banker, George T., 1145 E. Jersey st., Elizabeth  
Baron, Leo E., 727 N. Wood av., Linden  
Baruch, Hilde, 202 Stiles st., Elizabeth  
Baruch, Rudolf J., 202 Stiles st., Elizabeth  
Beisler, Lawrence G., 1528 N. Broad st., Hillside  
Bender, Dorothea A., 61 DeHart pl., Elizabeth  
Bensley, Maynard G., 129 Summit av., Summit  
Berenson, Samuel J., 1012 E. Jersey st., Elizabeth  
Berman, Leonard M., 128 Summit av., Summit  
Berman, Sol., 351 Rahway av., Elizabeth  
Bernstein, Benedict J., 434 E. Front st., Plainfield  
Berry, C. Hartley, 129 Summit av., Summit  
Birrell, Russell G., 554 Westminster av., Elizabeth  
Bishop, Carl, 831 Madison av., Plainfield  
Black, Max S., 1320 St. George av., Linden  
Blair, Thomas D., 414 Park av., Plainfield  
Blatt, David, 960 Madison av., Elizabeth  
Bloch, Harry, 613 N. Broad st., Elizabeth  
Blumberg, Jack, 504 Westminster av., Elizabeth  
Blythe, Rowland P., 30 Springfield av., Cranford  
Bolanski, Kasimier J., 145 Marshall st., Elizabeth  
Booth, Walter S., 744 Rahway av., Elizabeth  
Boozan, Wm. E., 1139 E. Jersey st., Elizabeth  
Bourns, Edward G., 203 S. Euclid av., Westfield  
Bowles, Harry H., 36 Woodland av., Summit

Boyd, Robert P., 120 Martine av. S., Fanwood  
Boyer, Paul K., 129 Summit av., Summit  
Boyes, James G., 1326 Chetwynd av., Plainfield  
Breslow, Alexander E., 930 Pierpont st., Rahway  
Brethwaite, Samuel H., Jr., 129 Summit av., Summit  
Brock, H. F., 417 W. Broad st., Westfield  
Brokaw, Chris. A., 1405 North av., Elizabeth  
Brown, L. Greeley, 173 Madison av., Elizabeth  
Brown, William H., 29 Third st., Elizabeth  
Burritt, Norman W., 30 Beechwood rd., Summit  
Butenas, Joseph J., 300 First av., Elizabeth  
Callahan, Edward J., 124 St. Paul st., Westfield  
Canright, Cyril M., 34 Springfield av., Cranford  
Cantini, Raphael S., 147 E. 7th st., Plainfield  
Card, Charles F., 144 W. Milton av., Rahway  
Cardinale, Pasquale F., 654 East Jersey st., Elizabeth  
Carlisle, J. Mallory, 550 Hillcrest av., Westfield  
Carpenter, Cedric C., 129 Summit av., Summit  
Carsley, Sidney H., 19 Holly st., Cranford  
Casilli, Arturo R., 618 Newark av., Elizabeth  
Castaldo, Neil, 103 Lincoln av. E., Cranford  
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth  
Chapman, Otis P., 125 Broad st., Elizabeth  
Childers, Robert J., 604 Park av., Plainfield  
Chodosh, Maurice A., 606 Roosevelt, Carteret  
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth  
Comunale, Anthony R., 1709 Irving st., Rahway  
Conway, James V., 428 Elmora av., Elizabeth  
Coplin, George J., 510 E. Jersey st., Elizabeth  
Corbusier, Harold D., 612 Park av., Plainfield  
Cox, William T. R., 345 S. Broad st., Elizabeth  
Crabtree, Loren H., 142 Bellevue st., Elizabeth  
Crane, Norman T., 147 E. Seventh st., Plainfield  
Crankshaw, Orrin F., 1 Euclid av., Summit



- Cronin, Francis J., 730 South st., Elizabeth  
Currie, Norman W., 508 Central av., Plainfield  
Dalberg, Walter, 500 Cherry st., Elizabeth  
Davidson, E. Norwell, 102 East Elm st., Linden  
Davidson, Maurice M., 128 E. Grand av., Roselle Pk  
Davis, F. Cleveland, 129 Summit av., Summit  
Davis, James T., 1169 Elizabeth av., Elizabeth  
Davis, Stanton H., 212 E. 7th st., Plainfield  
Day, Willis B., 407 E. 7th st., Plainfield  
DeCesare, Ferdinand J., 500 Walnut st., Roselle Pk  
Decker, Charles T., 275 Orchard st., Westfield  
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth  
Demarest, Gerald B., 531 E. Broad st., Westville  
Dengler, Henry P., 260 Morris av., Springfield  
Deutsch, Nathan S., 300 W. 7th st., Plainfield  
Diamond, J. George, 512 W. Front st., Plainfield  
Doggett, E. Hugh, 916 Park av., Plainfield  
Dolsky, Irving, 509 N. Wood av., Linden  
duBusc, L. C. Victor, 399 Westfield av., Elizabeth  
Dunn, H. Irving, 610 Salem av., Elizabeth  
Durrah, Fred F., 310 Plainfield av., Plainfield  
Eason, Samuel W., 48 De Forest av., Summit  
Edgar, Malcolm S., 129 Summit av., Summit  
Ehrlich, Max, 721 N. Broad st., Elizabeth  
Esty, Geoffrey W., 629 E. Broad st., Westfield  
Feleppa, Edward E., 618 Springfield av., Summit  
Fiedler, Michael J., 247 Crawford ter., Union  
Fink, Stanley J., 107 Walnut st., Roselle  
Fitch, Thomas S. P., 916 Park av., Plainfield  
Fort, William B., 147 E. 7th st., Plainfield  
Foster, Frank L., 320 Springfield av., Cranford  
Fourcher, Kenneth R., Standard Oil Co., Linden  
Franklin, Joseph E., 191 North av., Hillside  
Franklin, Lewis J., 149 Jean ter., Union  
Freeman, Ray M., 922 Orchard ter., Linden  
Frieburg, George H., 1108, Anna st., Elizabeth  
Frohwein, Ida H., 125 Morristown rd., Elizabeth  
Gadomski, Casimir F., 331 So. Broad st., Elizabeth  
Galloway, George E., 163 W. Milton av., Rahway  
Gannon, Joseph M., 149 Crescent av., Plainfield  
Geary, Paul, 909 Park av., Plainfield  
Gelber, Isaac, 2052 Morris av., Union  
Gerendasy, Julius, 956 E. Jersey st., Elizabeth  
Gibb, Alice S., 339 Union av., Elizabeth  
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth  
Gilpin, Fletcher, 118 North av. W., Cranford  
Gittelman, Morton, 426 Westminster av., Elizabeth  
Glaser, Emanuel, 360 Linden av., Elizabeth  
Glass, Benjamin E., 609 Watchung av., Plainfield  
Glass, Harry L., 1009 Park av., Plainfield  
Glassner, Frank, 308 Chestnut st., Roselle  
Glasston, Hyman M., 628 N. Wood av., Linden  
Golden, William M., 236 W. Milton av., Rahway  
Goldfield, Harold H., 225 E. Jersey st., Elizabeth  
Goldmacher, Herman B., 113 Elmora av., Elizabeth  
Goldstein, Herman H., 318 W. Jersey st., Elizabeth  
Gonczy, Edward J., 420 Jersey av., Elizabeth  
Grant, William E., 1370 Morris av., Union  
Greenberg, Max, 29 W. Henry st., Linden  
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizabeth  
Griswold, Merton L., Jr., 947 Park av., Plainfield  
Guidi, Guido M., 212 Christine st., Elizabeth  
Hackett, Edw. J., 597 Westfield av., Westfield  
Hall, Winthrop II., 400 Elm st., Westfield  
Hallock, Wilton J., 650 Springfield av., Summit  
Hansen, Harry, 916 Park av., Plainfield  
Hanson, Carl G., 38, Springfield av., Cranford  
Haseltine, Sherwin L., 125 Broad st., Elizabeth  
Herrington, Lee R., 605 E. Broad st., Westfield  
Hill, Clarence T., 116 E. Hazelwood av., Rahway  
Hipple, Percy L., 230 Walnut st., Roselle  
Hnat, Frederick, 624 Newark av., Elizabeth  
Hoffman, Charles A., 302 E. 7th st., Plainfield  
Holland, Reuben J., 1026 Chandler av., Linden  
Holmes, Grace A., 1077 E. Jersey st., Elizabeth  
Holt, Evelyn, 261 Springfield av., Summit  
Holtzman, Michael, 167 2nd st., Elizabeth  
Horoschak, Anne, 974 Park av., Plainfield  
Horre, George W. H., 203 W. Jersey st., Elizabeth  
Hubbard, Harry H. V., 121 E. 7th st., Plainfield  
Hughes, Frederic J., 706 Park av., Plainfield  
Humphrey, Hubert G., 430 Downer st., Westfield  
Hunt, Thomas F., 528 Monroe av., Elizabeth  
Hutton, Frederick T., 915 Park av., Plainfield  
Imbleau, Joseph E. L., 2106 Morris av., Unionville  
Jacobs, Alan L., 1243 Stuyvesant av., Union  
Johnson, Harold F., 734 Park av., Plainfield  
Jones, Herbert E., 47 Elm st., Elizabeth  
Jones, Lewis H., 139 E. Grant av., Roselle Park  
Kaplan, Samuel D., 149 Bailey av., Hillside  
Kapp, Carl G., 440 Westminster av., Elizabeth  
Karshmer, Ernest E., 927 S. Wood av., Linden  
Keeney, Cadwell B., 137 Summit av., Summit  
Keil, Sigmund S., 1182 St. George av. E., Linden  
Kemper, Harry T., 224 Monmouth rd., Elizabeth  
Kibbe, Milton H., Station Hospital, Ft. Benning, Ga.  
Klein, Henry L., Merck and Co., Rahway  
Knauer, George, 930 Elizabeth av., Elizabeth  
Konzelman, Henry J., 65 King st., Hillside  
Kramer, Douglas W., 1019 Park av., Plainfield  
Krans, DeHart, Taunton State Hosp., Taunton, Mass.  
Krans, Edward S., 920 Park av., Plainfield  
Kreutz, Paul J., 363 Union av., Elizabeth  
Kuchlewski, Edward J., 224 E. Jersey st., Elizabeth  
Kushner, Alexander, 208 W. Milton av., Rahway  
Kwint, Jos. A., 139th Med. Reg., Ft. Bragg, N. C.  
Labow, Joseph J., 757 N. Broad st., Elizabeth  
Ladas, George, 305 Cherry st., Elizabeth  
Laird, George S., 127 Central av., Westfield  
Lance, Elton W., 125 W. Milton av., Rahway  
Larrabee, Callie H., 24 Hobart av., Summit  
Lathrop, Frederic W., 909 Park av., Plainfield  
Laurie, Andrew L., 664 Newark av., Elizabeth  
Lawrence, William H., 129 Summit av., Summit  
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield  
Leggett, Thomas H., Jr., 706 Park av., Plainfield  
Lepree, Joseph A., 371 Morris av., Elizabeth  
Lerman, Irving, 1024 E. Jersey st., Elizabeth  
Lewis, Albert, 41 Retford av., Cranford  
Lieberman, David P., 597 Westminster av., Elizabeth  
Lieberman, Milton L., 101 Pershing av., Roselle Pk  
Lilien, Milton M., 152 Clark st., Hillside  
Linke, James J. P., 245 E. Front st., Plainfield  
Livengood, Horace R., 587 Westminster av., Elizabeth  
Llull, Gabriel J., 266 Morris av., Springfield  
Losado, Camella A., 19 Prospect st., Summit  
Lowell, Milton E., 434 Summit av., Westfield  
Lowenstein, Ernest C., 1492 Main st., Rahway  
Lufburrow, Chas. B., 441 W. Front st., Plainfield  
Lyerly, James M., 121 E. 7th st., Plainfield  
Lynch, Edward T., 748 Livingston rd., Elizabeth  
MacBrayer, Reuben A., Office Sur. Gn., U.S.A., Wash., D.C.  
Maggio, Ross J., 206 Park av., Westfield  
Malatesta, Chas. S., 1203 Martine av., Plainfield  
Marone, Carmine R., 752 Newark av., Elizabeth  
Maroney, James H., 129 Summit av., Summit  
Marts, George H., 956 Park av., Plainfield  
Mastroianni, Frank M., 901 Colonial av., Union  
McAlpine, Paul, 129 Summit av., Summit  
McCallion, Wm. H., 722 Westminster av., Elizabeth  
McGeary, John A., P. O. Box 88, Elizabeth  
McGinn, Wm. J., 1913 Westfield av., Scotch Plains  
McKinley, C. Scott, 232 Victor st., Scotch Plains  
Meeker, John L., 6 De Barry pl., Summit  
Meineke, William C., Jr., 818 Chestnut st., Roselle  
Merlo, Francis A., 210 Murray st., Elizabeth  
Merlo, Francis V., 33 Prince st., Elizabeth  
Miller, Robt. M., 382 Springfield av., Summit  
Milligan, Robert S., 42 Elm st., Summit  
Mills, Stephen D., 132 S. Euclid av., Westfield

Minnella, Thos. J., 132 Morris av., Summit  
Montfort, Robert J., 1051 E. Jersey st., Elizabeth  
Morris, Karl E., 903 Boulevard, Westfield  
Morris, Thomas M., 505 Park av., Plainfield  
Morris, Watson B., 193 Morris av., Springfield  
Munger, Ray T., 727 Watchung av., Plainfield  
Murphy, Albert T., 1108 Anna st., Elizabeth  
Murphy, Herschel S., 320 Chestnut st., Roselle  
Murray, Norman L., 129 Summit av., Summit  
Nadler, Arthur A., 532 W. Front st., Plainfield  
Naidorff, Saul A., 421 W. 7th st., Plainfield  
Newbury, Graham C., 209 Holly st., Cranford  
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth  
Novello, Joseph A., 641 Second av., Elizabeth  
Nussbaum, Joseph, 321 Elmora av., Elizabeth  
Obester, Gabriel E., 640 N. Broad st., Elizabeth  
O'Brien, Edwin J., Jr., 507 Park av., Plainfield  
Oderr, Charles, 116 S. Euclid av., Westfield  
Orton, Foster, 196 Elm av., Rahway  
Orton, George L., 196 Elm av., Rahway  
Osher, Morris M., 157 North av., Fanwood  
Owen, Philip, 1273 Stuyvesant av., Union  
Paulson, Arch M., 160 E. 7th st., Plainfield  
Pearl, Sydney S., 545 Rahway av., Elizabeth  
Peters, Richard C., 963 Park av., Plainfield  
Phelan, Walter F., 124 Chilton st., Elizabeth  
Pittis, Harold E., 818 Park av., Plainfield  
Polshuck, Ruben, 100 Hollywood av., Hillside  
Polk, Charles C., 114 E. 7th av., Roselle  
Prout, Thomas P., 19 Prospect st., Summit  
Quin, John A., 1100 Bryant st., Rahway  
Read, Jessie D., 519 Lenox av., Westfield  
Reich, Jerome J., 1500 N. Broad st., Hillside  
Reiner, Jacob, 311 N. Broad st., Elizabeth  
Reiter, Walter A., 50 DeForest av., Summit  
Relyea, George M., 129 Summit av., Summit  
Ripps, Maurice L., 410 Elmora av., Elizabeth  
Robertson, Grace M., P. O. Box 537, Hollywood, Fla.  
Rose, Abraham, 326 So. Broad st., Elizabeth  
Rosenblatt, Max B., 525 Court st., Elizabeth  
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall  
Rubin, David, 200 E. Jersey st., Elizabeth  
Runnells, John E., Bonnie Burn Sanaa, Scotch Plains  
Sadoff, Joseph, 116 Elmora av., Elizabeth  
Salvati, Leo H., 275 Orchard st., Westfield  
Samuels, S. Lawrence, 219 W. 7th st., Plainfield  
Satulsky, Emanuel M., 652 Park av., Elizabeth  
Schaefer, Phyllis A. D., 236 Kent Pl. Blvd., Summit  
Schenk, Joseph R., 1177 Park av., Plainfield  
Schiller, Edwin, 449 Westminster av., Elizabeth  
Schiller, Rosa O., 449 Westminster av., Elizabeth  
Schilling, Anthony B., 727 Jefferson av., Elizabeth  
Schlein, David, 812 No. Wood av., Linden  
Schlichter, Chas. H., 556 N. Broad st., Elizabeth  
Schwartz, Samuel H., 1044 Park av., Plainfield  
Schweizer, Roman G., 36 Summit rd., Elizabeth  
Seeler, Albert O., 33A Garden drive, Roselle  
Sell, Frederick W., 167 W. Emerson av., Rahway  
Sena, Dominic R., 1554 Irving st., Rahway  
Senerchia, Fred F., Jr., 604 Westminster av., Eliza.  
Seybold, Arthur D., 1030 Rahway road, Plainfield  
Seymour, George A., 253 Orchard st., Elizabeth  
Shangle, Milton A., 34 Prince st., Elizabeth  
Sherman, Samuel H., 81 Elmora av., Elizabeth  
Shirrefs, Russell A., 348 Elmora av., Elizabeth  
Silverman, Theodore M., 105 Elmora av., Elizabeth

Sims, Richard V., Jr., 31 Morris av., Summit  
Singer, Bella, 640 Wyoming av., Elizabeth  
Siy, John L., 382 Springfield av., Summit  
Smith, Meyer L., 289 Hilton av., Vauxhall  
Spirito, Michael W., 219 S. Broad st., Elizabeth  
Spivack, David, 376 Elmora av., Elizabeth  
Stanton, Nathaniel B., 734 Park av., Plainfield  
Staub, E. Milton, 531 E. Broad st., Westfield  
Steele, Stephen, 10 West Gibbons st., Linden  
Stein, Emil, 607 Park av., Elizabeth  
Stein, George H., 640 Wyoming av., Elizabeth  
Stein, Isadore, 817 N. Broad st., Elizabeth  
Stein, Martin H., 60 Elmora av., Elizabeth  
Steinberg, Werner, 35 Gesner st., Linden  
Stephenson, Gordon A., 145 Summit av., Summit  
Steuart, David F. R., 11 De Barry pl., Summit  
Stevenson, G. McKay, 129 Summit av., Summit  
Stillwell, Harry C., 51 W. Milton av., Rahway  
Strauss, Clifton J., 960 Springf'd av., New Providence  
Strelinger, Alexander, 650 N. Broad st., Elizabeth  
Strom, Abraham, 410 W. 7th st., Plainfield  
Stuart, J. Earle, 552 E. 2nd st., Plainfield  
Stybel, Joseph, 806 W. Front st., Plainfield  
Suffness, Gustave, 1151 Elizabeth av., Elizabeth  
Taranto, Michael, 731 N. Wood av., Linden  
Tator, Arthur E., 57 DeForest av., Summit  
Terrell, Edward E., 16 Alden st., Cranford  
Tidaback, John D., 332 Springfield av., Summit  
Tomlinson, Rolland D., 445 E. Broad st., Westfield  
Townsend, Leslie M., 420 Chestnut st., Roselle Park  
Triarsi, Anthony J., 702 3rd av., Elizabeth  
Tyndall, Alice E., 263 Walnut st., Westfield  
Tyndall, Martha W., 263 Walnut st., Westfield  
Vinciguerra, Michael, 604 Westminster av., Elizabeth  
Vitale, Dominic V., 745 N. Broad st., Elizabeth  
Vitolo, Ralph E., 934 Orchard ter., Linden  
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth  
Wacker, William F., 1224 Salem av., Hillside  
Wade, Simon F., 555 Newark av., Elizabeth  
Wagner, Otto, 111 Stiles st., Elizabeth  
Wagner, Richard, 612 N. Broad st., Elizabeth  
Walsh, Ronald J., 118 E. 5th av., Roselle  
Walsh, Thomas J., 335 S. Broad st., Elizabeth  
Ward, Leo J., 137 W. Jersey st., Elizabeth  
Webb, Eleanor A., 837 Springfield av., New Providence  
Wegryn, Louis S., 257 Elizabeth av., Elizabeth  
Weigel, Edgar W., 970 Park av., Elizabeth  
Weigel, Elmer P., 727 Watchung av., Plainfield  
Weissberg, William W., 1170 Liberty av., Hillside  
Weissman, Meyer T., 947 E. Jersey st., Elizabeth  
Weltchek, Herbert, 240 Lincoln av., Elizabeth  
Western, Frederic B., Knollwood road, Short Hills  
Whinery, Joseph F., 53 Templar way, Summit  
Williams, Frank A., 324 W. Jersey st., Elizabeth  
Williams, Leonard D., 915 Park av., Plainfield  
Wolff, Jerome M., 1414 Martine av., Plainfield  
Wolgin, Philip L., 445 Elmora av., Elizabeth  
Woody, McIver, 454 Union av., Elizabeth  
Wuester, William O., 238 Exter way, Hillside  
Yellin, Charles H., 525 E. Second av., Roselle  
Yood, Raphael, 401 Grant av., Plainfield  
Yorke, Edward T., 2300 Summit ter., Linden  
Young, Franklin C., 120 Summit av., Summit  
Yuckman, Robert O., 224 W. Jersey st., Elizabeth  
Zeitlin, Herman H., 943 N. Wood av., Linden  
Zingales, Joseph A., 101 Holly st., Cranford

Number of Active Members and basis of representation, 350.

#### Honorary Member

Montfort, Robert J., Elizabeth

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

Active Members

- Baldauf, Herman, Jr., Front st., Belvidere  
Boquist, Walter A., 380 Hudson st., Phillipsburg  
Bossard, Harry, R. D. No. 2, Phillipsburg  
Bostwick, Wallace R., Main st., Blairstown  
Brasefield, Edgar N., 218 Chambers st., Phillipsburg  
Buchanan, Ralph M. L., 8 Market st., Phillipsburg  
Cummins, George W., 202 Mansfield st., Belvidere  
Drake, Paul F., 85 Summit av., Phillipsburg  
Dresel, Irmgard, Far Hills  
Gordon, Frank S., Blairstown  
Humbert, Joseph C., Jr., Stewartsville  
Kassow, Philip B., North Blvd., Alpha  
Kimmel, Seymour S., Oxford  
Krausz, Emery, 577 S. Main st., Phillipsburg  
Lemmon, Junius M., 28 W. Wh'ngton av., Wash'gt'n
- Lyon, Charles H., 79 Lewis st., Phillipsburg  
Marlett, Neumann C., 230 Greenwich st., Belvidere  
Maxwell, Carl A., 117 Grand av., Hackettstown  
McMurtrie, William A., Far Hills  
Shevitz, David M., Grand av., Hackettstown  
Shimer, Floyd A., 88 Lewis st., Phillipsburg  
Smith, Herman, 397 S. Main st., Phillipsburg  
Smith, J. Meredith, 212 Grand av., Hackettstown  
Spillane, Timothy H., 379 S. Main st., Phillipsburg  
Vail, William P., Blairstown  
Varney, William H., 122 Belvidere av., Washington  
West, Guernsey F., 109 S. Main st., Phillipsburg  
West, Heston R., 109 S. Main st., Phillipsburg  
Wolf, Frank A., 494 S. Main st., Phillipsburg  
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THE MEDICAL SOCIETY OF NEW JERSEY

March 16, 1942

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Atlantic	131		Somerset	67
Bergen	295	3	Sussex	26
Burlington	62		Union	350
Camden	180		Warren	30
Cape May	26			
Cumberland	63		1941 Official List	3,948
Essex	1,057	59		3,768
Gloucester	50		Increase in Active Members	180
Hudson	480			
Hunterdon	27		Deaths of Members during year	50
Mercer	247	10	Transfers in from other States	5
Middlesex	157	21	Transfers out to other States	4
Monmouth	139	1	Transfers within the State	8
Morris	117		New and Reinstated Members	201
Ocean	32	3	Delinquents (Members in 1941, not paid up for 1942)	241
Passaic	382	12		
Salem	30			







# THE JOURNAL

OF

## THE MEDICAL SOCIETY OF NEW JERSEY

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### CONTENTS—Pages 311-360

#### EDITORIALS—

	Page
SPEED UP .....	311
MY FRIEND DR. POTTLESMITH .....	312
CARE OF THE INDIGENT AS A "BY-PRODUCT" .....	312
"RELATIVITY" WITH APOLOGIES TO EINSTEIN .....	313
ECONOMY .....	313
PROTECTOR OR POLICEMAN .....	314
"MALINGERERS" .....	314

#### THE WAR—

Procurement and Assignment in New Jersey .....	315
Russian War Relief .....	317
New Jersey Defense Council .....	318

#### ORIGINAL ARTICLES—

WOUND INFECTIONS—DIAGNOSIS AND TREATMENT —Irvin E. Deibert, M.D., Camden, N. J. ....	319
POST-OPERATIVE COMPLETE FACIAL PALSY WITH RECOVERY (Report of a Case)—Albert F. Moriconi, M.D., Trenton, N. J. ....	322
SOME PROBLEMS IN THE MANAGEMENT OF CAN- CER OF THE RECTUM—Homer I. Silvers, M.D., Atlantic City, N. J. ....	323
DISCUSSION, A. L. Reich, M.D., Newark, N. J. ....	326
TREATMENT OF THROMBOPHLEBITIS—Stuart Z. Hawkes, M.D., Newark, N. J. ....	328
TREATMENT OF GENERAL PERITONITIS OF APPEN- DICEAL ORIGIN—Russell K. Tether, M.D., Closter, N. J. ....	331
TREATMENT OF THE INFERTILE PREGNANT PA- TIENT. Maternal Welfare Article No. 70— Thaddeus L. Montgomery, M.D., and Harry L. Stewart, M.D., Philadelphia, Pa. ....	333
A LESSON FROM A DEATH CERTIFICATE .....	339

#### STATE ACTIVITIES—

	Page
Members Serving in the Armed Forces .....	340
Supplementary List of Members .....	342
Opiferque Per Orbem .....	342
Adulteration of "Dope" Peddled in Illicit Traffic .....	343
With New Jersey Medical Authors .....	343
New Jersey Chapter of Chest Physicians .....	343
New Legislation on Hernia .....	344

OBITUARIES .....	344
------------------	-----

BULLETIN BOARD .....	345
----------------------	-----

#### COUNTY SOCIETY REPORTS—

Atlantic, Burlington, Camden, Cumberland ..	346
Essex .....	347
Gloucester, Hudson .....	348
Middlesex, Morris .....	349
Ocean, Passaic .....	350
Salem, Somerset, Union .....	351
Summit Medical and N. N. J. Dermatological Societies .....	353

#### WOMAN'S AUXILIARY—

Down with the County Lines .....	354
"O" Is for Ocean County .....	354
"P" Is for Passaic County .....	354
"W" Is for Warren County .....	355
Auxiliary Reports .....	355

THE BOOK SHELF .....	357
----------------------	-----

TUBERCULOSIS ABSTRACTS .....	359
------------------------------	-----

Roster of Officers, Advertising Page 3a

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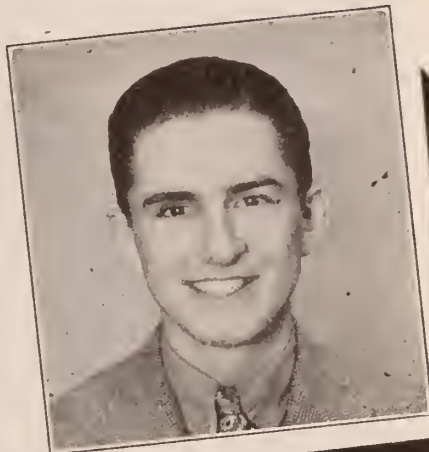
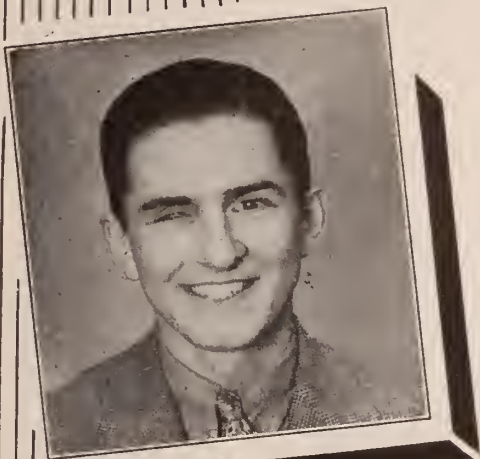


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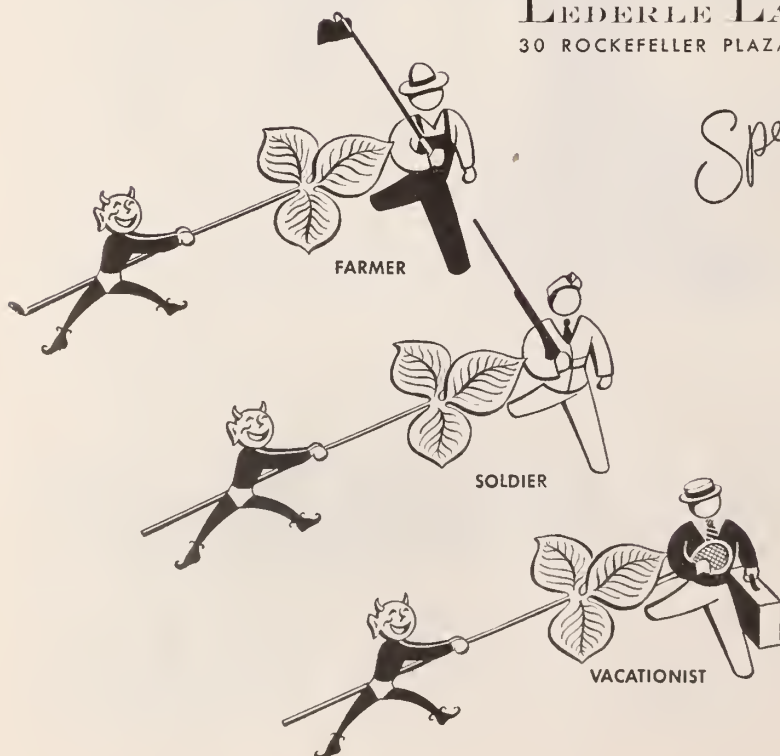
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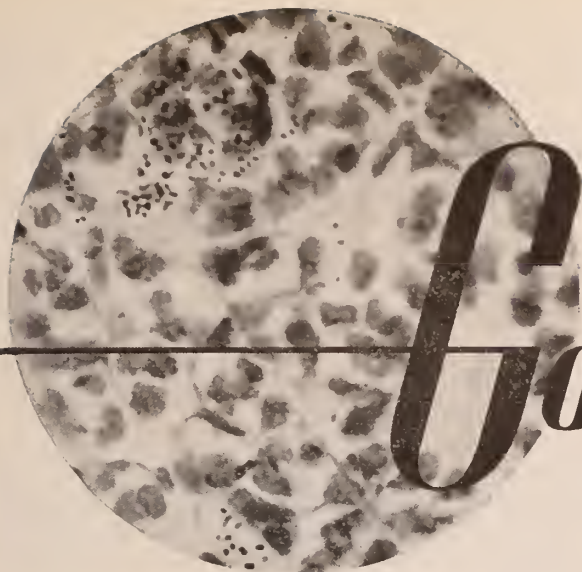
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- (1) 1939. The Canned Food Reference Manual, American Can Company, New York.  
1938. Commercial Fruit and Vegetable Products, Second Edition, W. V. Cruess, McGraw-Hill, New York.  
1937. Appertizing or the Art of Canning; Its History and Development, A. W. Bitting, Trade Press-room, San Francisco.  
1936. A Complete Course in Canning, Sixth Edition, Press of "The Canning Trade," Baltimore.



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1. Levin, E. A. & Keddle, Frances: *J. A. M. A.* 118:368, 1942

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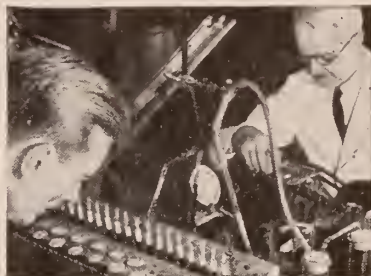
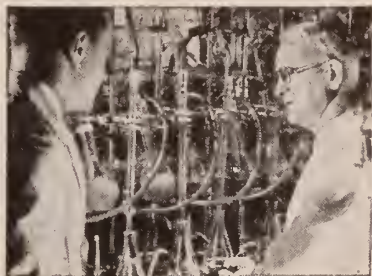


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Patients are apt to be quite thankful for your recommendation of a change to Camels. Slow burning, which according to scientific tests produces less nicotine in the smoke,\*\*\* also provides a milder, mellower, more flavorful smoking experience. Slow-burning Camel's blend of finer, more expensive tobaccos is famous for its "pleasure factor."



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\*\**The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941

\*\*\**J.A.M.A.*, 93:1110—October 12, 1929  
*Brückner, H.*—*Die Biochemie des Tabaks*, 1936

REPRINT AVAILABLE of an important contribution to the medical literature on smoking—"The Cigarette, The Soldier, and The Physician," *The Military Surgeon*, July, 1941. There are many new angles on smoking experience revealed in this analysis—an aid to you when modifying patients' smoking without disturbing their smoking enjoyment. Write to Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

# CAMEL

THE CIGARETTE OF COSTLIER TOBACCOS

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The Better Vision Institute will conduct a tremendous advertising campaign during the next year—with full pages in “Life”, “Saturday Evening Post”, “Collier’s”, “Time”, “American”, and “Nation’s Business” using the above theme “Vision for Victory”.

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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154. *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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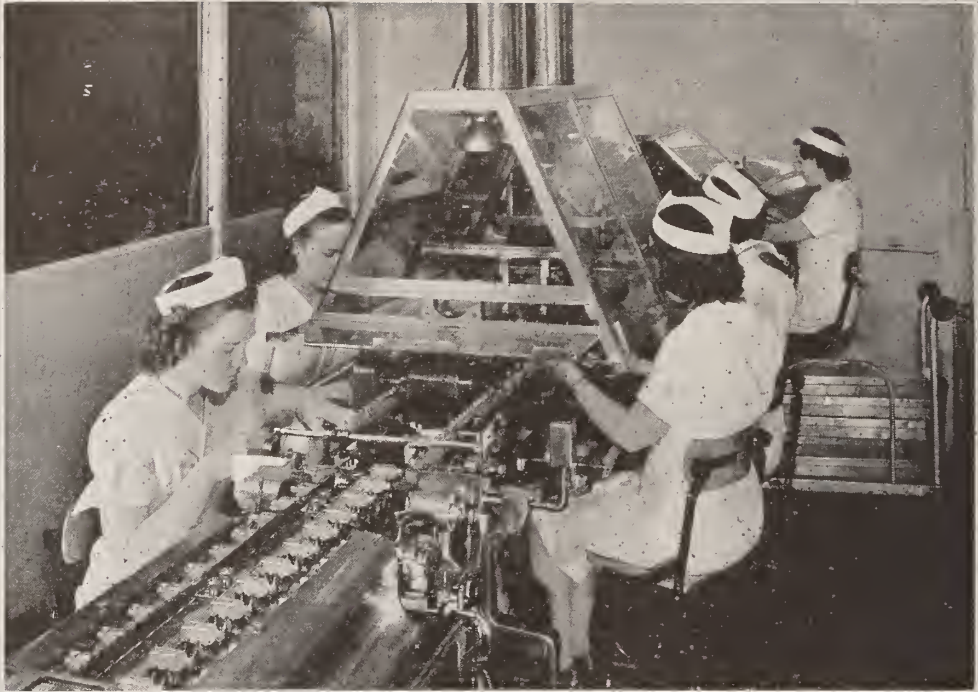
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OF

## THE MEDICAL SOCIETY OF NEW JERSEY

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HENRY A. DAVIDSON, M.D., Editor  
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### SPEED UP

The Medical Officer Recruiting Board representatives are speeding up the commissioning of physicians for the rapidly increasing army. Dr. Robert H. Lowe, M.C., U. S. A., is in charge of this work in Southern New Jersey, and in Northern New Jersey Lt. Col. W. E. Lippold, M.C., U. S. A., is in charge of this effort to cut the *red tape* which has handicapped this effort up to this time. These men are working in the interest of the physicians because the Surgeon General needs physicians and is anxious that they be kept out of the selective service draft for men in the ranks of the army. Members of the Society under 46 years of age should sign up quickly so they may be assured of a commission and serve where they are best fitted and where they will be happiest in the work they are called upon to do. *Act now.*

The *time* factor has never been quite

so definitely appreciated as *now*. The reason is a compelling one—self-preservation. This appreciation is extending more than ever to the medical profession as an *organization*. We are streamlining our structure and procedure to eliminate wasted effort and time, because we will have *less time and less personnel* available in our state and community from now on. Already we are demonstrating that we *can* save time and effort by delegating responsibilities to competent aides after pointing out our objectives, and the guiding principles and policies under which we agree to do our share of the work. Small committees of well-chosen men who can get things done are most efficient when given a job to do. Discussions must be kept at a minimum consistent with fairness. Action must *begin* at the earliest time at which a program and plan is made available and a leader is recognized and approved.

Physicians have always recognized the need for prompt action in emergencies where they are *individually* concerned, and now the need for *organized* action is being appreciated as never before. That

"everlastin' teamwork of every bloomin' soul" that Kipling mentions is everywhere needed, and The Medical Society of New Jersey can be trusted to do its full share in this effort.

---

### MY FRIEND DR. POTTLESMITH

The tendency of modern medical practice is to restrict by its demands upon his time the private practitioner to intensive and almost exclusive studies and observations regarding his professional problems. Yet by systematized effort, well planned and scheduled, the busy practitioner *can* enlarge his interests, increase his knowledge and skills, improve his powers of observation and deduction, and provide for himself a real stimulus and satisfaction now too often dulled by intensive studies confined to his specialized field.

Every person, especially every physician, needs an avocation — a hobby — preferably an outdoor one which differs widely in its demands from those of his

vocation. I have just read in "The Print Collector's Quarterly" of October, 1941, an article by the late Dr. A. Graeme Mitchell, famous pediatrician of Cincinnati, whose accomplishments and expertness in his avocation of etching and painting were well known by his colleagues. The article is entitled "Pottlesmith on the Art Critic". A cartoon of Dr. Mitchell as "Dr. Pottlesmith" accompanies the article.

Dr. Mitchell in this role brought the same joy to himself and to his many medical colleagues through his artistic contributions and comments, as he did to the many children and their parents he so successfully advised and treated during his brilliant professional career.

---

### CARE OF THE INDIGENT AS A "BY-PRODUCT"

The time-honored willingness of the medical profession to give cheerful and gratuitous service to the poor rested on the fact that in the early days of the century, care of the indigent was only a by-product of the physician's productive day. Any doctor worthy of the name was willing and able to give an hour or two a week to the care of the indigent set against 60 to 80 hours a week of productive service to private patients.

Such is the force of the cultural lag, however, that the momentum of this service has carried over far beyond the time when the free patient load constituted an easily handled proportion of the doctor's timetable. Today adequate

attention to the indigent sick calls for tremendous sacrifices of time and energy and imposes so heavy a burden on the shoulders of the practitioner that it is no longer a by-product of medical care, but is fast becoming one of the chief demands upon the doctor's working day.

As a result, although the doctor is still as willing as ever to give a more than reasonable ration of his time to the care of the indigent, this is possible under today's conditions only if part of the cost of this care is lifted from the doctor and is borne by the agencies which meet all the other needs of the indigent.

Older physicians, who have long since

passed the time when they labor daily in the clinic, sometimes do not understand why the young doctor today finds so much difficulty in rendering free service; their tendency is to say: "When I was a young man, I did this cheerfully." They forget, however, that a young doc-

tor in 1942 is not in the same position as a young doctor in 1902. What is needed is an honest re-evaluation of the relative time demands for free and private medical service. Neither preaching nor prosecution will be of any avail unless such facts are clearly set down.

---

### "RELATIVITY" WITH APOLOGIES TO EINSTEIN

Even a fact can be more or less significant. In the last World War, we were told that "one-third of the flower of our youth was defective", but we won that war, and it is quite likely that there were many more defective soldiers in the other wars won by our country. Better methods naturally increase our skill. We are again warned that "the draft examinations show a still higher degree of defective youths", but many of the early rejectees will be in there fighting effectively beside the more perfect specimens before we are again at

peace. Quality is associated with quantity.

Minor defects are quite prevalent among the public, even when their presence is known to those affected, and the means are available for their correction. This is a plea for better interpretation of the true *significance* of certain statements in order that the presentation of facts shall not defeat the purpose for which they were presented. Perfection is an elusive goal toward which we approach slowly, and voluntarily by preference.

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### ECONOMY

Physicians as a group have never been considered economical in their use of time and effort in behalf of their patients. How much appreciation of these sacrifices has been shown by his patients each physician can best judge for himself, but *for the duration* at least, new elements must be considered. Gas, oil, tires and even the number of available physicians themselves must be conserved. The supply will progressively diminish as the war period is prolonged. Business-trained men use time and work schedules to increase their benefits to customers and themselves. They carefully plan each day's work, schedule a time for each effort,

and discharge their obligations on time. Physicians can profit by this example without any sacrifice of professional standards or satisfaction, and with increased service to the community and themselves. Let us, as members of Organized Medicine, start an educational campaign among our members and their patients to make them aware that conservation of time, effort, supplies, transportation must also include the medical profession. This conservation need not cause hardship on those who are really in need of emergency services.

Calls made to the home should be routed. The doctor cannot cover the



same route several times a day, but will respond to *real emergencies*. Calls must be placed with the physician's office early in the day to allow planning and scheduling of the day's work in the most effective and economic manner. Calls that come in late in the day may have to wait until the next day's schedule, unless an absolutely urgent situation is believed to exist. A statement to this effect can be issued by the medical profession and be approved by the Defense Council.

The unavoidable overload on the pro-

fession, individually and collectively, can be emphasized to the public. The decline in available physicians to operate free clinic service can also be stressed and the need emphasized that such services be strictly reserved for the indigent who have no other place to which they can look for help under the emergency conditions. Those who can afford to seek private care should not be allowed to usurp the only opportunity open to the indigent for whom service without charge is definitely intended.

---

### PROTECTOR OR POLICEMAN

Many patients still need to be convinced that their attending physician can help them only if and when they are themselves ready to carry out his advice. The physician is *not* a policeman. He is a professional *adviser* on health matters. The patient himself, with his doctor's advice and assistance, plays the more effective part in the maintenance or restoration of his own health. Without the patient's *full co-operation* in the health plan suggested, his physician can be of

little benefit. Nor will his physician himself gain the professional satisfaction of accomplishment which is to him as real a part of his reward as is the fee received in the practice of his profession. These rewards and his inherent desire to serve, lead the true physician to select the profession of medicine, and underly and make possible the voluntary services given by physicians in homes and hospitals and elsewhere which have always distinguished the worthy Sons of Aesculapius.

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### "MALINGERERS"

In prepaid medical service it is likely that many apparently healthy persons will consult a physician who would perhaps not otherwise do so. Some of these people will merely wish to gain a better understanding of what they are paying for. Others may be lonely and want someone to talk to—especially at night.

If our preventive services are all we hope and believe them to be this opportunity can be taken to extend their use. Also some of these may become patients

who have conditions of which they are unaware, and an earlier diagnosis and treatment may become possible. The result in economies of time and service offset the cost involved in satisfying a natural curiosity or desire to investigate something new.

Emotional disturbances are real to the patient, though this may have no discoverable physical basis. Modern physicians treat the patient as well as diseases and defects.

## THE WAR

### PROCUREMENT AND ASSIGNMENT IN NEW JERSEY

(MAY 20, 1942)

The very acute need for additional medical officers for the army has necessitated some important changes in the relationship and administrative routine between Procurement and Assignment Service, Selective Service System, and the Office of The Surgeon General.

To avoid repetition we request that you read carefully the following announcements appearing recently in the Journal of The American Medical Association:

1. New Method for Immediate Recruitment of Medical Officers (J. A. M. A., May 2, 1942, p. 33).
2. Occupational Deferments of Doctors, Dentists and Veterinarians (J. A. M. A., May 16, 1942, p. 268).
3. Physicians Needed Immediately for the Armed Forces (J. A. M. A., May 16, 1942, p. 264).

Let's not forget that Procurement and Assignment is an ideal, the child of the medical profession, the agency through which the members of the profession can best fulfill their obligations to their government at this time. It must be made to work; it can be made to work, and it is working beautifully in Northern New Jersey.

#### RECRUITING PHYSICIANS IN NEW JERSEY

##### NORTHERN NEW JERSEY

There are two Medical Officers Recruiting Boards operating in New Jersey. The North New Jersey Board covers the area north of Mercer County, inclusive of Middlesex County. It is in session daily including Saturday from 9 a. m. to 5 p. m. at the Sussex Avenue Armory, Newark. The President of the Board is Lt. Col. W. E. Lippold, Med. Corps. Col. Lippold and his staff are working in close co-operation with the state office of Procurement and Assignment. Physicians may feel assured of prompt, courteous, personal assistance when requested to appear before the Board.

Physicians reporting to Col. Lippold's Board are interviewed personally by Col. Lippold, assisted in making out the necessary application blanks and given a physical examination by physicians detailed from the Newark Induction Board. On the following day, when the physical examination and laboratory reports have been received by the Board, a "Letter of Appointment" is presented to each ac-

cepted applicant, he takes his "Officer's Oath" and the physician becomes an officer in the Medical Corps of the Army of the United States.

#### *Source of Applicants*

Physicians report to the Board from three sources:

##### *I. Individual Volunteers*

It is not necessary that physicians be cleared first through the Washington office of Procurement and Assignment. Any fully licensed physician under 45 years of age, wishing to enter active duty, may be commissioned by the Board in grade of Lieutenant or Captain, providing he is a citizen, a graduate of a Class A School and is declared "available" by Procurement and Assignment. Procurement and Assignment papers may be initiated by the Board and cleared through the Procurement and Assignment state office.

##### *II. Procurement and Assignment Volunteers*

The names of physicians declared "available" on papers received from the Washington office of Procurement and Assignment are referred to the Board. These physicians are notified by the P. & A. state office of this action and of their status. The Board contacts them by letter or telephone, requesting that they appear for an interview.

The name of each physician declared available, who is under 45 years of age, and who does not wish to accept a commission, or participate with Procurement and Assignment is referred to the New Jersey State Director of Selective Service System, for inclusion under the provisions of the National Selective Service Act.

##### *III. Class 1-A Selectees*

This office is notified by State Selective Service Headquarters of all physicians classified as 1-A by local Selective Service boards. The names of these physicians are forwarded to the Medical Officers Board for commissioning, providing the individual physician involved has not previously refused a commission.

##### SOUTHERN NEW JERSEY

The Southern New Jersey Board has its office at Fort Dupont, Delaware. Its President is Capt. Robert H. Lowe, Med. Corps, of

Fort Dupont. It covers the southern counties, including Mercer County, as well as the State of Delaware. Capt. Lowe is contacting physicians through attendance at county society meetings and by correspondence. The names of physicians declared as "available" through the Washington office of Procurement and Assignment are referred to the Board by this state office, as are the names of South Jersey physicians classified 1-A by local boards. Application forms furnished by Capt. Lowe are returned by mail to Fort Dupont. Accepted applicants are referred to Fort Dix or Fort DuPont for their physical examinations.

#### INITIAL RANK ABOVE CAPTAIN

Recruiting Boards may not grant rank above the grade of Captain. The names of physicians entitled to higher rank or requesting higher rank are referred to the Office of The Surgeon General for decision.

#### INTERNES

All internes about to finish one year of internship should report immediately to the Board unless they already hold commissions. They may be commissioned within one year of graduation from medical school without a state license. To be commissioned after one year has elapsed necessitates the holding of a state license or a certificate from the National Board.

#### ESSENTIABILITY OF STAFF MEMBERS

To assist the State Chairman in determining "availability" each New Jersey hospital has submitted a list of staff members deemed essential for the operation of the hospital.

These essential men should be, and usually are, men over 45 years of age, or men with known physical defects.

The State Chairman must, except under unusual circumstances, declare staff members under 45 years of age as "available", when their names are received from the Washington office of Procurement and Assignment. Neither can Internes who have finished one year's internship or Residents be declared essential unless they are physically unfit for military service. In such cases the hospital involved should take immediate steps to find a suitable replacement.

#### DUTY WITH AIR CORPS

Physicians wishing duty with the Air Force should address "Office of Air Surgeon, U. S. Army, Washington, D. C." The necessary forms and instructions will be forwarded from that office. All forms when completed should

be returned directly to the Office of Air Surgeon, U. S. Army.

#### MARRIED VERSUS SINGLE MEN

A common criticism is that many single physicians are not being made "available" while those with families are being declared "available" and placed on active duty. The State Chairman of Procurement and Assignment has suggested to the Washington office that they send through "availability forms" on all single physicians and physicians with one dependent. This procedure had previously been considered by the Washington office, but could not be adopted for the reason that all male citizens under 45 during this war period have an equal responsibility, and such a procedure would be interpreted as group discrimination. Local Selective Service Boards are the only units having such discretionary power.

#### NUMBER OF PHYSICIANS IN SERVICE

There are at present approximately 600 physicians from New Jersey on active duty with the Army or Navy. The total by December should be between twelve and fifteen hundred.

#### THE YOUNG PHYSICIAN

To maintain high standards of health and physical fitness of the soldiers in our combat units, to assure efficient professional care and transportation of each individual soldier who may become a casualty, and to develop a medical organization in each combat unit which will assure these accomplishments, is the greatest direct contribution which the young physician can make toward the winning of this war. This initial care may be, and frequently is, the factor determining the life or death of a soldier, or the degree of rehabilitation which may be possible during later stages of his medical care. Without this assurance and accomplishment there cannot be high efficiency and high morale among our soldiers in combat. This is the answer to the questions and arguments advanced by physicians under 37 years of age. The needs of the army differ from the needs of a community. These needs must be filled.

The demonstration by the young physician that the profession is willing to and capable of fulfilling this important obligation may have an important effect upon the respect and consideration shown physicians, and upon the course of the practice of medicine in the future. Let's fill these needs voluntarily. May no soldier in a combat unit be deprived of efficient professional care and transportation during and immediately following combat.



CONSULT PROCUREMENT AND ASSIGNMENT

The undersigned will be glad to consult with any physician concerning his special problems or his relationship or obligation to the war effort.

IF YOU ARE UNDER 45 YEARS OF AGE THERE SHOULD BE NO DOUBT IN YOUR MIND AS TO YOUR OBLIGATIONS TO YOUR GOVERNMENT AT THIS TIME.

NORMAN M. SCOTT, M.D., Secretary  
N. J. Procurement and Assignment Service  
31 Clinton Street, Newark, N. J.  
Phone Mitchell 2-0675

CHARLES H. SCHLICHTER, M.D., Chairman  
N. J. Procurement and Assignment Service  
556 North Broad Street, Elizabeth, N. J.  
Phone Elizabeth 2-5054

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THE FOLLOWING TELEGRAM WAS RECEIVED ON MAY 22ND  
FROM THE SURGEON-GENERAL, U. S. ARMY:

DOCTOR CHARLES H SCHLICHTER  
556 N BROAD ST ELIZABETH N J

MAY 22 AM 8 15

\* \* \* MAY EIGHTEEN SOUTH JERSEY TO BE REMOVED  
FROM JURISDICTION OF DELAWARE BOARD ADDITIONAL BOARD  
BEING REQUESTED FOR SOUTH JERSEY AT PRESENT SOUTH  
JERSEY CANDIDATES MAY BE HANDLED BY NORTH JERSEY  
BOARD END SPMCM

MAGEE—WASHN DC.

\* \* \*

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RUSSIAN WAR RELIEF

Joseph E. Davies, former United States Ambassador to Russia, spoke to more than one thousand people on Sunday evening, March 29th, 1942, at a dinner sponsored by the Medical and Allied Professions of Essex County, a subcommittee of Russian War Relief, Inc., of Essex County, at 744 Broad Street, Newark.

In a letter to Stuart A. Young, Chairman of the Essex County Committee, Mr. Davies stated that he had never spoken to a more enthusiastic and responsive audience. He paid tribute to the fact that the Medical and Allied Professions had been the first to institute the campaign in this county for medical relief and stated that it was most fitting that the opening of the campaign should attract such a splendid attendance of medical men.

After a brief resumé of the history of the past few years, Mr. Davies spoke of the tremendous sacrifices and suffering of the Russian people and of their courageous and heroic fight. He said, "The Soviet Union is fighting with an heroic unselfishness that has commanded the respect of friend and foe. It has

done so with a degree of intelligence and foresight that has heaped shame on its critics \* \* \* the Russians are worthy comrades. It makes my blood boil to hear people talking about the possibility that the Russians may quit or fall out. Whenever anyone tells you that, remind him that the Germans are paying gold to their own followers to disseminate that falsehood. And talk of Stalin quitting is playing the Nazi game."

Ex-ambassador Davies concluded his stirring remarks by emphasizing the tremendous need of our Russian Allies for medical aid.

Governor Edison also was a guest speaker and spoke in glowing terms of the fight the Russian people are making. After the meeting, the Governor contributed very handsomely to the fund, which, at the present time, has exceeded six thousand dollars as a result of the proceeds of the dinner alone.

At the conclusion of Davies' speech, Mr. S. M. Barlow, New York author and critic, who was the toastmaster, appealed for funds. Also at the speaker's table were Dr. Max Danzis

and Dr. Royal A. Schaaf, Medical Committee co-chairmen, who presided and who are still performing a most worthy service in enlisting the coöperation of practically the entire county in this effort.

Members of the Medical and Allied Professions Committee included the following:

Dr. Max Danzis and Dr. Royal A. Schaaf, Chairmen; Dr. A. B. Abrams, Dr. William Antopol, Dr. George Banker, Dr. C. W. Barkhorn, Dr. H. C. Barkhorn, Dr. Frank A. Bien, Dr. Joseph A. Clarken, Dr. Harry Comando, Dr. Sidney Danzis, Dr. R. H. Dieffenbach,

Miss Minnie Edelshick, Dr. E. W. Erler, Dr. Rita Finkler, Dr. J. I. Fort, Dr. B. A. Furman, Dr. I. Gelber, Dr. L. M. Goldman, Dr. Frederick Hnat, Dr. Stuart Z. Hawkes, Dr. George Horre, Dr. J. W. Hurff, Dr. J. J. Kashkevich, Dr. George Lada, Dr. Clymont MacArthur, Dr. Eugene V. Parsonnet, Dr. Maurice Ripps, Dr. Charles M. Robbins, Dr. Jacob Schaffer, Dr. Milton Shangle, Mr. O. Singer, Dr. Edward W. Sprague, Dr. A. Wegrocki, Dr. Abraham Wolfson, Dr. A. C. Zehnder, Dr. William Zimmer, Miss Adele Zweiman.

## SIMPLE AND PRACTICAL POINTS TO REMEMBER ABOUT CHEMICAL WARFARE AGENTS

### SUMMARY

#### NEW JERSEY DEFENSE COUNCIL (MAY, 1942)

1. *With good gas discipline there is less chance of enemy resorting to chemical warfare; fewer casualties if chemical warfare agents are used.*
2. *Detection—Odor identification is reliable.*
3. *Pulmonary Irritants.*
  - A. Treat every unprotected individual as a casualty until proved otherwise.
  - B. Every casualty must be a stretcher case and must have immediate evacuation—the casualty with cyanosis gets priority in evacuation.
  - C. Immediate treatment is rest, warmth, hot drinks, reassurance.
  - D. Therapy—Oxygen and venesection only when venous pressure elevated.
4. *Vesicants.*
  - A. Eye contamination—a definite emergency—irrigate boric or bicarb: no bandage.
  - B. Skin contamination—liquid more serious than vapor.
  - C. Pulmonary irritation with secondary infection responsible for most of the fatalities with mustard.
  - D. Contaminated Clothes—remove as quickly as possible.
  - E. Learn correct technique in the attempted removal of agents from the skin.
  - F. Protective cream, or bleaching paste mixtures or sodium hypochlorite good prophylactic agents against mustard agent; hydrogen peroxide good prophylactic agent against lewisite.
  - G. Prophylactic agents not used when the actual lesion has developed.
  - H. Therapy of the actual lesion non-specific in type.
5. *Heat Burns.*
  - A. Little local treatment for the extensive burn—evacuate to installation where general therapy may be given at once—definitive treatment.
- B. Emergency treatment—may be given to minor burn.
- C. Try to prevent infection of the burn area at all times.
- D. No crusting techniques on face, wrists, hands, feet, genitalia.
- E. Plasma usually the intravenous agent of choice.
- F. In fixed hospital installations where definitive treatment can be given—local therapies include crusting technique plus sulfadiazine, pressure technique.
6. *Eye Lesions.*
  - A. Prevention—gas mask, goggles (less efficient—ophthalmic cream).
  - B. Learn correct technique of irrigation with simple materials.
  - C. Do not use cocaine—use butyn.
  - D. Do not bandage contaminated or irritated eye.
  - E. In tear gas demonstrations, do not allow individuals to rub eyes.
7. *Evacuation of casualties.*
  - A. Various units in the chain; learn function of each in regard to chemical warfare casualties, first aid posts, casualty stations, gas decontamination stations, decontamination wings of hospital, hospitals.
  - B. Learn possibilities for immediate care to casualties on the street—individual showers and baths in the home; so-called mobile decontaminating units.
  - C. Immediate evacuation to decontamination wing of hospital of contaminated casualty plus shock or plus severe hemorrhage or plus pulmonary irritation.
8. *Decontamination—general principles of in regard to clothes, food, water, medical supplies.*

## ORIGINAL ARTICLES

### WOUND INFECTIONS — DIAGNOSIS AND TREATMENT\*

By IRVIN E. DEIBERT, M.D., Chief of Surgical Service "B", Cooper Hospital,  
Camden, N. J.

In order to properly diagnose and treat wound infections, some type of *classification* is necessary. The following classification has been chosen, due to the fact no discussion would be complete today without the inclusion of war wounds:

1. Classification:
  - A. Accidental or Traumatic
  - B. Intentional or Surgical
  - C. Wounds Associated with Compound Fractures
  - D. War Wounds Due to High Explosives
2. Prevention of Infection and Prophylaxis
3. Bacteriology, Wound Culture, etc.
4. Treatment:
  - A. General: Drugs, Vitamins, etc.
  - B. Surgical: Cleansing, Debridement, etc.
  - C. Chemical Therapy: Use of the Sulfa Drugs, Zinc Peroxide, etc.
  - D. Blood Changes Associated with Wounds, Hypoproteinemia

War wounds and those due to our ever-present traffic accidents have much in common. It must be remembered traffic wounds far outnumber war injuries and will be with us long after the war is over. Diagnosis and treatment apply equally to both.

In order of frequency, infections from accidental or traumatic wounds far outnumber the intentional, or more properly, the surgical wounds. The traumatic type of wound must of necessity be subdivided into the following:

1. Wounds associated with compound fractures.
2. Wounds due to high explosives, complicated by the introduction of foreign bodies.

Wounds of the chest, abdomen, and cranial cavity must receive special consideration.

All traumatic wounds naturally have one thing in common: prevention of infection, or prophylaxis. Treatment of traumatic wounds starts with first-aid. Sulfanilamide powder, if available, should be dusted into the wound and the wound covered with a sterile dressing. Adequate hemostasis should be secured with the judicious use of a tourniquet, only when absolutely necessary. The tourniquet only to be left on a few minutes at a time. *The importance of this act cannot be too strongly emphasized.* We are all familiar with the fact a tourniquet is many times applied when it is not necessary and many times left in place far too long, sometimes resulting in the loss of a limb, or even the patient's life, to say nothing of minor permanent disabilities.

Even though no fracture is present, it is often better to splint the part. After the patient has arrived at the hospital, or has been placed under competent medical care, attention should be directed to combating shock, if present, and to the proper treatment of the wound. With the present availability of serum, whole blood, and fluids, the excuse of waiting for the patient to react from shock cannot be validly used. Many times both the shock and the wound can be treated concurrently. The patient should be given a dose of tetanus antitoxin, or if he has had the immunizing dose of tetanus toxoid, an additional 1 c.c. may be given.

The patient is anesthetized, if necessary, and cleansing of the wound started. This is best accomplished by scrubbing with soap and water, or benzene, or both. The wound itself is kept covered with sterile gauze and attention should be directed to the cleansing of the skin first.

\* Read before the Annual Meeting of The Medical Society of New Jersey, April 22, 1942, at Atlantic City, N. J.



After this is thoroughly cleaned, the wound is next considered. A simple scrubbing is not sufficient—this must be thoroughly done, using copious quantities of sterile water. Following this, debridement, with the removal of all dead tags and destroyed tissue, with a thorough exploration of all the crannies and corners, but certainly there should be no destruction of good tissue.

The foregoing procedure should accomplish the following things, namely: normal color, slight bleeding, and contractility of muscle tissue, if present. Adequate hemostasis is now secured. Then, a light dusting, or what might be termed a generous salting, of the wound with one of the sulfonamides, preferably sulfanilamide. If the wound is capable of being closed, non-absorbable sutures, preferably silk, may be placed in the wound, but not tied. A generous and firm dressing is then applied and the part splinted for rest if necessary. The wound is not touched for from 48 to 72 hours. If after this time the wound is clean, the sutures may then be tied. This is the so-called primo-secondary suture.

The foregoing statements are, of course, based on the assumption that this wound was seen at a reasonably early time, preferably the first six hours. No gun-shot, high explosive wound, or wound of any severity, should be sutured as a primary procedure. Obviously these principles do not apply to small, clean-cut lacerated wounds about the hands or face, such as wounds due to flying bits of glass, or other material. Wounds associated with compound fractures are treated in a like manner with the exception of the reduction of the fracture. Length must be maintained and the parts thoroughly immobilized in a plaster cast, using wire, pins or nails to accomplish this, if necessary.

Wounds due to high explosives, and the introduction of foreign bodies in many instances call for the removal of the foreign body. In so far as the location of metal objects is concerned—the instrument developed by Dr. John Morehead should be used, if available. This is a highly developed and most accurate instrument and is effective on practically all the metals. It was used by Dr. Morehead

at the recent Pearl Harbor incident, with a high degree of success. It is my understanding this instrument will shortly be available.

Wounds of the chest will not be dealt with in detail, except to call attention to the necessity for the earliest possible emergency treatment to the sucking type of wound. Every effort should be directed to the prevention of this phenomena as soon as possible, and this is best accomplished by the application of a large tight dressing to stop this action.

Wounds of the abdomen call for special attention dependent upon the injury to the particular viscus involved. The same general principles apply. This is also true of injuries to the cranium and its contents. It is our own belief, however, the skull and its contents should be left in the hands of the neurosurgeon, if possible.

The intentional, or surgical wounds, which have become infected should also include those traumatic wounds which have become infected. To Meleney and his associates considerable credit is due for their investigation and work on wound culture. An infected surgical wound should have a culture made as soon as possible. Facilities should be maintained for doing both aerobic and anaerobic types of culture. The ordinary aerobic culture alone is not sufficient, as it will not detect the so-called micro-aerophilic group and the anaerobic organisms. It is upon these two latter groups that the zinc peroxide is most effective. It should be definitely pointed out the technique of Meleney must be followed, if his good results are to be obtained. The value of zinc peroxide depends upon the ability of this compound to liberate free oxygen into the wound. This cannot be accomplished unless the zinc peroxide is kept constantly in the fluid or semi-fluid state. Therefore it is important the dressings be kept moist at all times. This can readily be done by using first a layer of wet gauze and then a layer of vaseline gauze. This is then covered with wax paper and sealed with adhesive. If these few points are kept in mind, the use of zinc peroxide is many times highly satisfactory, particularly in combating the aforementioned group of organisms.

The use of the sulfonamides by mouth must

of necessity be largely a matter of individual judgment and is governed by certain definite principles. If a specific culture can be obtained, either locally or from the blood, the particular compound which best combats that organism can be selected. Local and blood concentration of the drugs used must be considered. Generally, it is not considered safe to produce a blood concentrate of more than 10 or 15 mg. per 100 c.c. of blood. When these drugs are administered by mouth the concentration is never higher in the tissue fluids. Jensen, Johnsrud and Nelson have shown that 8 grams placed in the average wound will give a tissue fluid concentration of approximately 250 mg. per 100 c.c. This amount in turn will give a blood concentration of 5.9 mg. per 100 c.c. This seems to be the average. However, there is reason to believe that this is a variable factor in different individuals and in different types of wounds. Certainly great care should be exercised in the administration of the sulfonamide group in the extremely ill or shocked individual. If a definite blood stream infection is present, the drug is of necessity invaluable. Just what local concentration of the sulfonamide group is necessary to destroy a given organism will be an interesting fact to know. At present it would seem the greatest value of the use of this drug locally is it creates an unfavorable place for the growth of many microorganisms.

General supportive treatment is given, and any existing vitamin deficiency should be restored. One should also bear in mind delayed healing and stubborn infections may be favorably influenced by treatment of hypoproteinemia. Hence, blood protein should be determined, and if there is a deficiency it may be restored by the use of whole blood or plasma.

Adequate splinting and rest cannot be too strongly emphasized. Certainly it is no disgrace to splint a wound where no fracture is present. As has been pointed out by Treueta and Barns, defusion of bacteria from wounds is mainly by the lymph channels. These writers have shown proper splinting and rest will decidedly retard the flow of lymph, or even stop it. Frequent dressings and the use of strong antiseptics are to be avoided in order

not to destroy the fine membrane which forms over granulation tissue and is shown to be often practically impervious to the passage of bacteria.

Gas gangrene and serious infections will not develop in the wound that has been seen early and thoroughly cleaned, and not sutured. Severe infections cannot develop in wide open wounds. However, all wounds may not be seen during the golden period of the first six hours and may not have had the benefit of early treatment. Therefore, one will undoubtedly see an occasional case of gas gangrene. Again the sulfonamides offer considerable help, zinc peroxide is of great value and x-ray therapy may be tried. It is our feeling radical amputation is seldom necessary if the patient is seen reasonably early after the occurrence of the gas infection. It has been our experience that deep longitudinal incisions extending from above the line of gas through the skin and superficial tissues down to the muscles have many times saved a limb. Gas serum, of course, should be used. Its value is debatable. From the foregoing statements it should be emphasized again that irrigations and strong antiseptics are contraindicated.

In conclusion, serious infections including gas gangrene do not develop in wide open wounds and those that are not sutured. If there is any doubt, be the wound ever so small, do not suture. Do not use irrigations and strong antiseptics. Adequate proof of this is evidenced in the failure of Dakin's solutions, and the *multiplicity* of antiseptic solutions, none of which are ideal.

With the sulfonamides we are undoubtedly entering a new era, and indeed we now have a powerful ally. When given by mouth in seriously injured individuals, it must, however, be judiciously used. By the use of whole blood, plasma and fluids, it is possible to combat severe shock and to start treatment almost immediately. There is little or no necessity to wait for the patient to react from shock. Treat shock by the above methods while treating the wound. An attempt has been made to simplify the classification of wounds, and to emphasize the *principles* of treatment rather than the detailed technique of individual types.

## POST-OPERATIVE COMPLETE FACIAL PALSY WITH RECOVERY \*

### REPORT OF A CASE

By ALBERT F. MORICONI, M.D., Trenton, N. J.

G. H., aged 18, had intermittent discharge from his right ear for 13 years. A mastoidectomy had been performed 11 years ago, but his ear has continued discharging.

Left ear was normal. Right ear showed a yellow, musty smelling discharge in the canal. A perforation in the anterior-superior angle of tympanic membrane was filled with a polypoid mass. No tenderness was elicited over mastoid. Nose was normal, throat clear.

Audiometer: 45.5 per cent loss of hearing for speech in right ear, 18 per cent loss in left.

Laboratory: No abnormalities found.

X-ray: Bone destruction present.

On the basis of the history, clinical findings and great loss of hearing for speech a diagnosis of chronic mastoiditis was made and a radical mastoidectomy was decided upon. This was performed on 3/29/40. While shaving down the posterior canal wall, after removal of bridge, a small nutrient vessel began bleeding. Since I had not reached the level of the floor of the middle ear I continued shaving down the wall and struck a large vein. I pressed the bone at this point to stop the bleeder. Upon uncovering the face of the patient a right facial palsy was noticed. The immediate post-operative recovery was uneventful, the patient being discharged from the hospital after six days.

No improvement in the paralysis was noticed after two weeks and faradic and galvanic testing showed no muscular movements. Dr. B. A. Hirschfield (neurologist), who examined him, believed he had a complete reaction of degeneration. A few days more were allowed to elapse, but no return of nerve function being found, the possibility of complete severance was considered and an exposure of the nerve

was decided upon. This was done 4/30/40. The facial canal was exposed from the stylo-mastoid foramen to middle ear. A thickening of the nerve sheath and a swelling due to granulation tissue were found at the angle immediately lateral to the horizontal semicircular canal wall, where the nerve enters the middle ear. The sheath was split, covered with vaselinated gauze and wound closed.

No change in paralytic state was noticed until two months later when some voluntary movements at the angle of mouth were seen. Many treatments were given with the faradic current and gradual improvement took place until complete recovery six months later. At present writing no palsy is present and ear is dry.

#### SUMMARY

1. A case of post-operative facial palsy with subsequent uncapping of facial nerve is reported.
2. The completeness of the RD was the deciding factor for reëntering the wound. A complete severance of the nerve was deemed possible, hence the haste.
3. The findings at operation did not bear out this latter possibility.
4. The writer believes the uncapping was justified as had there been a severance an end-to-end anastomosis would have been possible at this early date.
5. Eventual recovery from injury of the facial nerve as herein described might not have taken place.

438 Hamilton Avenue

### MEDICAL TEACHERS WANTED

The Red Cross is anxious to secure physicians willing to serve as instructors in first aid. Any Doctor of Medicine is considered qualified to teach, if he will secure, read and follow the standard text book prepared by the Red Cross for this purpose and arrange the time

for class instruction. Doctors willing to do this work are requested to apply immediately to the nearest Red Cross Chapter. Each Chapter is listed in the telephone director as "American Red Cross".

\* Read before Philadelphia Laryngologic Society, March 1941.



## SOME PROBLEMS IN THE MANAGEMENT OF CANCER OF THE RECTUM\*

By HOMER I. SILVERS, M.D., F.A.C.S.

Chief of the Department of Colonic and Rectal Surgery, Atlantic City Hospital,  
Atlantic City, N. J.

The history of surgical intervention in cancer of the rectum is one of a long struggle to overcome the handicap of high mortality and at the same time to remove sufficient tissue to insure a reasonable tenure of life in those surviving the operation.

The first removal of the rectum was accomplished by Lisfranc in 1826, it being a form of posterior resection, limited apparently to a circular removal of the lower end of the rectum.<sup>1</sup> This operation and those that were to follow were woefully inadequate in their removal of invaded tissue. Most of these no doubt were low lying and below the peritoneal reflexion. Despite what must have been discouraging fatalities, the work was carried on by such men as Diffenbach, Velpeau, then later Verneuil, who removed the coccyx.

Then came the man whose name has come down through the years as associated with extirpation of the rectum. Kraske, in 1885, before a conference of German surgeons, presented a resumé of the work done in cancer of the rectum and then proposed new and advanced methods of dealing with this disease. So well associated has his name become with operations on the rectum that the title "The Kraske Operation" is often applied to all forms of posterior resections. This operation was advocated and used by many surgeons, as it offered for a considerable time the most radical form of extirpation. From this operation gradually arose many variations whose value was only determined after many years. After long use it became apparent that this type of operation did not remove enough of the possible cancer-bearing tissue to insure a reasonable percentage of cures in all types of rectal malignancy.

Then came the combined abdominal-perineal excision which had in it the principle of wide removal of all potential cancer-bearing tissue.

Shortly after the turn of the century, Miles gave to the medical world his technique of removal of rectal growth by a combined abdominal-perineal dissection. This work no doubt was based upon the work done by Von Volkmann in the late eighties. To Mr. Miles we are indebted for a study of the spread of metastasis and with it a comprehensive plan for the removal of tissue that formed the pathway of extension. There have been many modifications proposed, but they all have the inherent principles of Miles as a basis. Now after 35 years, this operation has been accepted by most surgeons as the operation of choice, the one most likely to give the highest percentage of cures.

All types of people are afflicted with cancer; it is no respecter of race or creed, although the Negro seems to enjoy a lower ratio of incidence. According to Raiford at the Johns Hopkins Hospital, the disease appeared in the white in the ratio of eight white to one colored. In a series reported by Rankin there were only three colored patients in 424 cases. Curiously in our series, the youngest patient for whom we performed a resection was a colored girl.

The size of the rectal growth is not an index as to how thorough or radical should be its removal; there is no relationship between the size of the cancer and its potential malignancy or rate of spread. The planning of limited operations for small or moderate-sized growths should be condemned; actually the large fungating mass that is projecting into the lumen may be less malignant than a smaller one that has penetrated the wall of the gut. It has been shown repeatedly that *size bears no relationship to metastatic spread*.

\* Presented before the Section on Gastro-Enterology of the Annual Meeting of The Medical Society of New Jersey, April 22, 1942.

1. Rankin, Fred W.: Cancer of the Rectum and Rectosigmoid. Surg., Gyn., Obs., Vol. 72, Feb. 1, 1941.

Gilchrist and David<sup>2</sup> have shown very graphically the spread of metastases and the need of wide excision if all cancer-bearing tissue is to be removed. Specimens studied by them showed 20 to 80 nodes per specimen with an average of 52.1 nodes per specimen removed by the Miles type of abdomino-perineal resection. They also showed that low-lying tumors may have metastasis very much higher, and that where lymph channels are blocked by metastasis there may be retrograde extension downward and *against* the normal lymph flow. It becomes obvious then that a primary problem is to plan an operation that will provide for the widest removal of tissue that may contain secondary areas of cancer.

The finding of metastasis in the liver signifies the spread of cancer cell by the *blood* stream and this may occur at any time during the growth of the neoplasm. Ordinarily this liver involvement does not appear as quickly as the lymphatic spread in the contiguous tissue, but it can and does occasionally show as palpable masses in the liver before enlarged lymphatic nodes can be felt.

The wide spread metastasis, particularly when the liver has been invaded, raises the question of how much, if any, surgery should be done. Here it becomes a nice question to decide what is best for the patient and how can he be kept most comfortable. It is obvious of course that involvement of the liver means a fatal termination. Where invasion of the liver is small or distribution limited there may be a considerable length of time intervene before a fatal termination, and in those cases we do not hesitate to complete the operation.

Removal of the irritating sloughing mass in the rectum makes more comfortable the patient's remaining life and avoids that terrible distressing pain and urging that is so commonly associated with advancing rectal cancer.

Age is a factor that must be taken into consideration in planning the type of operation. It would be folly to attempt a procedure upon a person so advanced in age that any surgical shock would probably be fatal. Mere years,

however, do not provide an index of operability; many people are older at fifty-five than their neighbor at sixty-five. While age may not determine operability it has a distinct bearing upon prognosis. Individuals below the age of thirty in whom cancer of the rectum is known to be present have a very poor outlook so far as cure is concerned. They will probably be good surgical risks and will survive the operation, but recurrence of the growth or metastatic extension is so common that a cure is not to be expected.

No cancer of the rectum is an emergency and no surgery directed at the removal of the growth should be attempted until after prolonged and proper preparatoin. These patients usually come to the surgeon after the disease has been present for a considerable time. In a series reported by Cattell,<sup>3</sup> 40 per cent had symptoms for six months or under, and 30 per cent had symptoms over one year. In this length of time various physiological changes have taken place. Bowel functions are not normal, usually shown by an attempt to evacuate the rectum frequently, the patient never being able to get away from the sense of urgency. Frequently this is spoken of as a diarrhea. Actually it is not, the dejecta being composed of mucus mixed with blood and watery exudate often containing portions of formed stool. Because of this constant discharge of liquid, many of these patients show a definite dehydration. It is extremely important that fluid balance be restored, and to do this intravenous methods are employed ordinarily using saline solution with glucose. This, if given in sufficient quantity, will increase tissue fluid and raise urinary output and at the same time restore the supply of carbohydrates in the liver.

Most of these patients have obstruction in some form and while *complete* obstruction is unusual, there will be found some distension of the large bowel. Often this distension of the gut does not depend upon the actual mechanical interference with passage of intestinal content, but rather a change in physiology. We have made an invariable rule that no resection

2. Gilchrist, Richard K., and David, Vernon C.: Lymphatic Spread of Carcinoma of the Rectum. *Ann. Surg.*, Vol. 108, No. 4, Oct., 1938.

3. Cattell, Richard B.: Carcinoma of the Rectum. *New Eng. Jour. Med.*, Vol. 208, pp. 740-744, Apr. 6, 1933.

be attempted upon a dilated gut. There are very few cases that can not be deflated by the use of small doses of a mild saline and repeated washings if sufficient time and care is spent in the endeavor. Should distension be severe and our effort fail to produce a satisfactory deflation, then we do not hesitate to perform a cecostomy. This, however, is necessary in only a small percentage of cancers that we see, but under all circumstances the abdomen must be soft and flat before we do a resection.

Anemia is a factor that varies greatly, some patients showing very little reduction in blood values, while others have a decided reduction (lowered red cell count and hemoglobin below 50 per cent). Where there is a distinct drop in the blood picture we give one or more transfusions, before operation. All patients without exception receive a blood transfusion at the time of operation or immediately following it, and this may be followed by subsequent transfusions.

It has been observed that obese people do not withstand operation as well as a person of more moderate build.<sup>4</sup> The operation is also more difficult and is apt to be prolonged. The wound is not only deeper but fat obscures the anatomy, and exposure is not so easily obtained. Vessels and metastatic nodules cannot be easily palpated and the movements of the surgeon's hands are hampered by the deposits of fat.

Because of the wider pelvis, some surgeons look upon women as a safer surgical risk and it is certainly true, the better the exposure the greater the ease in carrying out the wide dissection necessary to remove potentially infected tissue. Whether man or woman, good exposure of the whole field is desirable; particularly is this true when complications are encountered. In a recent abdominal perineal excision of the rectum in a man a loop of small intestine was firmly adherent to the growth deep in the pelvis. After dissecting the loop free from the growth it was necessary to resect a section of the small bowel because of infiltration of

its walls and this procedure was easily carried out because of wide exposure that we had in this patient.

These patients should not be subjected to operation before a thorough proctoscopic study is made. Much information can be gained by such a study, in establishing the position of the growth, the amount of fixation to surrounding tissue, the type of neoplasm, and when it is possible to pass the proctoscope beyond the growth, the condition of the bowel at a higher level is revealed.

The possibility of multiple malignancies must not be overlooked.<sup>5</sup> This multiplicity does not occur in any great number but is sufficient to justify care in the examination. Schreiner and Weber studied 307 cases of multiple carcinoma, of which seven cases involved the large bowel. Recently we did a resection of the sigmoid for carcinoma, and in this patient the proctoscopic examination preceding the operation disclosed two polyps in the rectum which biopsy showed to be carcinomatous.

A proper anesthesia well administered is a prime requisite in the successful performance of the surgery required to remove this diseased organ. It is impossible to carry on the necessary work with any degree of accuracy when the patient is resisting and the abdominal contents constantly being pushed down in the operative field. We have found spinal anesthesia to be admirably adapted to this type of work, giving a relaxed abdomen with flaccid intestines so that a minimum of packing is required and a wide exposure maintained.

TABLE I.

33 cases refused operation  
67 cases operated

TABLE II.

## VARIOUS OPERATIVE PROCEDURES

Abdomino-perineal .....	25
Perineal resection .....	14
Lahey .....	3
Colostomy .....	17
Exploratory .....	3
Local removal—radium .....	4
End to end .....	1

4. Mayo, C. W., and Schlicke, Carl P.: Carcinoma of the Rectum, Recto-sigmoid and Sigmoid: Selection of cases for one-stage combined abdomino-perineal resection. *Southern Surg.*, Vol. XI, pp. 14-23, Jan., 1942.

5. Silvers, Homer I.: Multiple Intestinal Carcinomata, Appearing Simultaneously. *Amer. Jour. Dig. Diseases*, Vol. VI, No. 1, pp. 25-27, March, 1939.



TABLE III.

LOCATION OF GROWTH	
Upper ampulla	67
Lower ampulla	20
Recto-sigmoid	13

TABLE IV.

AGE GROUPS	
Youngest patient	20 yrs.
Oldest patient	88 yrs.
50% occurred between ages of 60 and 80 yrs.	

TABLE V.

TYPE OF CANCER	
Adeno-carcinoma	100

Of 100 consecutive cases seen on the Proctologic Service of the Atlantic City Hospital, 33 refused operation. In this number there were quite a few that were suitable for resection and we have the information that some were operated upon in other localities.

Sixty-seven cases were submitted to operations that included many procedures intended for palliation; 42 patients were operated upon and some form of resection performed.

Adeno-carcinoma was the type of malignancy found in all of the 100 cases. In most of these cases the process was well advanced, the disease having been present in most instances more than ten months, and in a few had existed considerably longer than a year.

In our review of these cases it became quite apparent that too long a time elapsed between the onset of symptoms and the surgical intervention. Liver involvement and lymphatic extension were found too frequently, so that surgery planned for cure could not be used with any degree of satisfaction. It is extremely important that these cancers be caught *early* and that radical measure be instituted before there has been time for metastatic spread. Frequent rectal examinations, particularly in the presence of altered bowel function or the persistence of any unusual symptoms, will go far towards increasing operability and the restoration to comparative normal function of many that would otherwise be condemned.

## DISCUSSION

By A. L. REICH, M.D., Newark, N. J.

Dr. Silvers has very ably brought for our consideration a well-recognized pathological entity. The keynotes sounded today in this orderly presentation are diagnosis, morbidity, and mortality.

As to diagnosis, we have only one thought in mind; not the personal gratification of having made a correct evaluation of symptoms and findings, but rather the dissemination of knowledge which will bring us the early case of cancer. Unfortunately the case is late when the digital examination reveals the tumor, and the proctoscope presents the craterform, cauliflower, encircling neoplasm. Dr. Silvers' quotes of "six months to one year duration of the disease" being late are correct. Knowing the fact that rectal cancers are slow-growing tumors, it takes that length of time to become the size so readily recognized by digital and instrumental examinations. Changes of bowel habits are not always constant findings. A 59-year-old lady consulted us recently with no other complaint than one episode of bleeding, but examination already revealed a tumor the size of a hen's egg. Pain, we know, is always a very late symptom. In fact, I would consider it a complication. It is with great elation and self-satisfaction that we diagnose a polyp or adenoma which is so easily eradicated by cautery, dessication, or complete extirpation. Even these are often reported by the pathologist as already malignant. On the other hand, if these simple growths are left untreated, there are six chances out of ten that in time they will be full-grown malignant tumors. An

important factor in diagnosis of rectal cancer has been impressed on me recently. I refer to the barium enema x-ray examination. In each of the last three cases recorded as being negative, I was able by biopsy to diagnose a carcinoma of the rectum. This is no indictment of x-ray or roentgenologist. It is a recognized fact that x-ray examinations fail most frequently in tumors of the rectum. Where the approach lends itself to actual visualization, the x-ray is not needed, except to check for multiple lesions beyond the field of proctologic investigation.

As to morbidity, it is the aim of surgery to rehabilitate or alleviate the suffering of all patients. I agree with Dr. Silvers that resection of the involved rectum makes more comfortable the patient's remaining life. The exploration of the liver for nodules has a great bearing on prognosis, but it is not too strong an influence on the procedure of surgical intervention. The immediate prognosis is more accurately estimated, as is well stressed in this paper, by the factors of age, obesity, intestinal obstruction and laboratory reports of the blood examination. These findings may often be improved pre-operatively, and so raise the operability percentage.

As to mortality, I refer to the operative death percentages. Dr. Silvers has not taken this up in the body of his paper. I hope he will speak of this in his closing remarks. Table 2 shows that the

abdomino-perineal operation has been employed in the ratio of 2 to 1 over the perineal operation. My own experience has been greatly influenced by the operation suggested by Dr. Lynch of New York, which is a resection of the rectal or recto-sigmoid carcinoma by the perineal route. This is not just a low amputation of the rectum, but an intra-peritoneal dissection from below, with a perineal stoma instead of an implantation of the bowel in the abdominal wall, as a colostomy. Dr. Lynch has reported removing as much as 72 centimeters of bowel. My own experience includes a resection of 45 centimeters. The mortality rate of the abdomino-perineal operation ranges from low to high, depend-

ing on the clinic from which the report comes. For example, Dr. Silvers and I had the pleasure of listening to Dr. Binkley report only last week on some thirty-five or forty abdomino-perineal operations, with one death. The mortality rate is definitely influenced by the protracted abdominal dissection which appears to me to be more difficult than the same extirpation of bowel through the perineal approach. The time element is a great influence on shock. The Lynch operation is usually done within the hour. In our hands the operative mortality has been held below 5 per cent. The rate of recurrence is reported as being about the same in both operations.

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## TRANSPORTING HUMAN BLOOD

A simple and safe method of collecting, storing and transporting human blood plasma is suggested by Elmer DeGowin, M.D., and Robert C. Hardin, M.D., in a recent issue of *War Medicine*. DeGowin and Hardin found that the large glass flasks used in hospital for the storage of intravenous solutions, when equipped with a permanent rubber stopper allowing self-closing needle punctures, were eminently suitable for the collection, storage and administration of whole blood or of blood plasma. The blood is collected in the flask by use of a standard needle valve piercing the rubber closure enabling a satisfactory mixture of the blood with a preservative fluid already in the flask. They say that when the needle is withdrawn the puncture hole in the rubber closes and that the flask can be immersed in ice water for long periods of time without leakage.

The question of storage of such flasks under proper refrigeration involved the problem of devising some means by which it would be indicated whether refrigeration had been properly observed.

A simple glass tube was designed into which was poured an acid mixture found to have a melting point between 50 F. and 55.4 F. A red or blue glass bead was inserted which sank to the bottom. The mixture was then solidified by immersing the tube in an ice bath, and a similar glass bead was placed on top. The tube was corked and attached to the neck of the flask.

"If the tubing was heated to the melting point of the mixture for about ten minutes," the authors say, "the upper bead sank, and thereafter both beads remained together no matter in what position the two might be when the mixture was refrozen.

"This method of refrigeration is adapted to transportation by almost any type of vehicle or airplane. The only limiting factor is the accessibility of cracked ice or snow at the end of every eighteen to twenty-four hour period during transportation. Any truck driver can be instructed to inspect the cans every twenty-four hours and can be trusted with the duty of reicing them when necessary. The refrigeration indicators constitute a final check on whether this duty has been performed.

"The transportation of blood in individual refrigeration units ought to be particularly practical under shell fire, for the cans could be disbursed in many types of vehicles so that some would almost certainly arrive at their destination."

To determine the effect of transportation on stored blood, two shipments of cans containing the flasks were sent on automobile trips of 720 and 731 miles. Another shipment was sent by plane from Iowa City to Oakland, Calif., and back, a total distance of 3,539 miles.

All of the bloods in both tests were then transfused into hospital patients requiring such treatment and in only one instance was there any reaction out of forty transfusions.

## TREATMENT OF THROMBOPHLEBITIS \*

By STUART Z. HAWKES, M.D., Med. Sc.D., F.A.C.S., Newark, N. J.

In this presentation I would especially like to bring to your attention some recent developments in the treatment of thrombophlebitis, on which interest has been focused during the past year. Predicated upon the theory of Leriche announced about ten years ago, Ochsner and De Bakey<sup>1</sup> have provided clinical proof which has crystallized our thought upon this subject.

All of us have seen cases of thrombophlebitis of post-partum, traumatic, postoperative, or spontaneous origin; and we have all seen the bad results obtained in many of these patients, in spite of the most accepted treatment. Formerly this treatment consisted of a period of bed rest of six to eight weeks with the use of heat and elevation of the leg; followed by a period of support of the affected part by an elastic bandage or stocking when the patient is out of bed and on restricted activity. In spite of proper care, however, only too often swelling of the leg persisted, sometimes for the rest of the patient's life. Permanent damage to the circulation resulted, as indicated by the persistent lymphoedema of the leg. The damage often caused ulceration of the skin due to tissue fluid stagnation, sometimes making an invalid out of one who had previously been well. Because of these repeated bad results, this new method is important if it decreases our morbidity. It deserves a serious trial.

### PATHOLOGICAL PHYSIOLOGY

In order to understand the theories in back of this new treatment and to appreciate its clinical application, the effect of the sympathetic nervous system on the peripheral vessels, both arteries and veins, must be reviewed. For some time it has been known that the sympathetic nervous system had a tonic contractile effect on the peripheral arteries. More recently it has been appreciated that it also

has an effect on the peripheral veins. Should a phlebitis occur, a reflex spasm is established through the sympathetic reflex. This arc sends and afferent impulse back to the central nervous system from the affected vessel and then relays an efferent impulse out to the sympathetic ganglion. A contractile impulse is then transmitted to the peripheral arteries and veins of the affected extremity causing spasm. Similarly vasospasm occurs with acute embolism, thrombosis, or any injury involving either an artery or vein.

Formerly thrombophlebitis was thought to involve primarily the larger vessels of the thigh and pelvis. We now know that involvement of even a very small vessel under the calf muscles of the leg will cause reflex spasm throughout the leg. This fact is important because sometimes it is very difficult to realize that thrombophlebitis exists, unless such a small vessel is kept in mind. At times there is very little evidence of what we used to think of as the clinical picture of thrombophlebitis, with a cord-like structure in the thigh that can easily be felt. At the beginning only fever and increased pulse rate with pain in the calf may be present, with no oedema and no pain or induration in the region of the femoral vein or over the thigh. A good point to remember in diagnosis is that pressure over the calf muscles will elicit sharp pain if the small veins beneath are involved. The small thrombus in the calf vein is enough to cause reflex spasm in both the arteries and the veins throughout the leg.

As a result of the diminished arterial blood, there is ischemia of the part with resulting paleness and lowered surface temperature. The spasm in the veins causes an increased venous pressure with an increased filtration and capillary bed pressure, thus producing lymphoedema. The combined result produces an enlarged pale leg.

If this pathological condition of the circulation exists over a period of time, we have fibrosis produced in the capillary bed due to

\* Read before the Annual Meeting of The Medical Society of New Jersey, at Atlantic City, May 20, 1941.

1. Ochsner, A., and De Bakey, M.: Thrombophlebitis: role of vasospasm in production of clinical manifestations. *J. A. M. A.*, 114:117-124, (Jan. 13) 1940.



the lack of oxygenation and to the increased venous back pressure. In time permanent lymphoedema resulting from the fibrosis of the lymphatics and small veins occurs.

The purpose of the treatment then is to prevent the efferent reflex impulses from reaching the arteries and veins, by blocking these impulses at the lumbar sympathetic ganglia in the lower extremity and at the stellate ganglion in the upper extremity. If the reflex arc is interrupted at these points by the injection of novocaine around the ganglia no efferent sympathotonic spasm of the artery and vein is possible in the extremity.

#### PROCEDURE

To reach the ganglia controlling the lower extremity, the spinous processes of the lumbar vertebrae are palpated and identified. A point is selected about an inch and a half lateral to the spinous process and a small wheal is raised in the skin. A needle is then inserted about an inch coming down on the transverse process of the vertebra, which is used as a landmark to allow identification of position. The needle is then withdrawn slightly and redirected somewhat upward and inward along the vertebral body to its anterolateral surface, where the sympathetic ganglion lies. Eight to ten cc. of 2 per cent novocaine is injected. If the needle comes within several millimeters or even a centimeter of this ganglion, anaesthesia will most probably be produced by infiltration of the ganglion. It is therefore not necessary to strike the ganglia itself to produce the desired result. It is important not to insert the needle too far. On the left side lies the aorta and on the right side the vena cava. Care is required not to enter the retro-peritoneal tissues and injure these structures. The final depth of the needle is estimated by using the depth of the transverse process as one of the guides. The depth varies with the person's build and muscular development, lying deeper in short, heavy-set muscular individuals, and more superficial in the thinner, taller and less muscular patients.

If the ganglia is reached, a change in the temperature in the affected limb can be felt by the time the procedure is finished. The affected extremity is found to be warmer than the

other, while before the block, the affected extremity was colder, paler and blanched, as well as being swollen. This temperature rise in the damaged leg is a good indication of whether a block of the sympathetic ganglia has been produced.

If the procedure is required in the upper extremity the stellate ganglion is blocked. It is approached between the carotid and vertebral arteries, and is found lying in the same relative anterolateral position on the vertebral body as the lumbar ganglia. It is reached by selecting a point one inch above the midpoint of the clavicle and inserting a needle at a 45-degree angle from the median plane of the neck directly down on the vertebral body, keeping the needle parallel with the upper surface of the clavicle. When the vertebral body is reached, at a depth of from three to five centimeters, the anaesthetic solution is introduced. If the anaesthetic solution is correctly introduced an immediate Horner's syndrome occurs on the anaesthetized side. The production of this syndrome is an indication of whether the sympathetic impulses have been interrupted.

The proposal to block the stellate ganglion suggests danger and that many important structures might be penetrated. Trouble can, however, be avoided by carefully observing landmarks, keeping in mind the position of the underlying subclavian artery and vein running between the clavicle and the first rib, and by remembering also the position of the carotid and vertebral arteries.

Should a novocaine solution be used the block will last only as long as the novocaine effect lasts—a matter of several hours. Other solutions can be used which have a more prolonged effect. These are prepared in an oily base to insure slower absorption of the anaesthetic agent.

The effects last about a week by slowing the rate of diffusion. Low dilutions of alcohol, 15 to 20 per cent, may also be used to obtain a still more lasting effect. By breaking the reflex arc only temporarily (several hours), the spasm is often relieved, and once broken the normal arterial and venous tone is reestablished and persists. Evidence of this is found in the fact that sometimes just producing the block

once with plain novocaine will give permanent relief. However, the procedure may have to be repeated and if necessary, it may be repeated three or four times without danger or untoward results.

#### CASE REPORT

M. B., white female, aged 27; married, no children.

She had an appendectomy performed in December, 1940. On the tenth day after the operation, when she was about to get out of bed, she said she had a peculiar feeling in her left leg. She complained of fullness and tightness in the thigh. The postoperative course had been absolutely uneventful. She had had no complications. She was found to have a temperature of 100 degrees, a pulse of 94, and respirations of 20 per minute. The wound seemed clean and was superficially well healed. The next night the leg became swollen and it was tender and enlarged. Diagnosis was made of a postoperative thrombophlebitis in the left leg.

It was decided to perform a sympathetic block in the left lumbar region. After the block her temperature did not return to normal as hoped, and the pulse did not fall. The leg became somewhat smaller and quite some warmer but only temporarily. It began to show evidence of returning vasospasm after thirty-six hours. A second lumbar sympathetic block on the same side was again performed, using one per cent novocaine. The affected leg had been larger in size than the well leg. After the first block the size diminished, but it was still larger than the unaffected leg. After the second block it diminished to normal size, enlarged again for several days, and then remained permanently smaller than the well leg.

After the first block the skin temperature in the affected leg became higher than in the well leg. Then over a period of thirty-six hours it began to fall until it again was lower than that of the

well leg. Here was additional proof that a second block was necessary. After the second injection the temperature in both legs remained about equal, but the temperature of the bad leg always remained a little higher, even long after all effects of the novocaine had disappeared. Even after seven or eight days the skin temperatures of the affected leg were still higher than that of the good leg. It is to be recalled that only 1 per cent novocaine was used, so that its anaesthetic action could not have produced this prolonged effect. No slowly absorbable novocaine or alcohol was used. The relaxation of vascular tone following the temporary interruption of the sympathetic vasospastic impulses is an interesting matter. As has been stated, the effects have lasted in several cases long after any effect of the anaesthetic agent has gone. The cause of this is the basis for further study. The answer cannot be given at this time.

We have treated about twenty similar cases in the past year with very good results. The patient is kept in bed for one week following the block. He is not in bed for six weeks, as once was done, and yet he is not allowed up immediately. Certain physicians feel that the patient can get up the day after a block if the temperature of the extremity increases and the swelling is reduced. Certainly there is the possible chance of an embolism if they are ambulatory too quickly. However, we feel that one week is a sufficient period of rest and if their symptoms have subsided in that time, we feel that they can get out of bed.

We have obtained better results with this type of treatment than from that previously used, i. e., bed rest, elevation, and local heat.

84 Washington Street

#### SULFATHIAZOLE IN INFANTILE DIARRHEA

Thirteen of 27 children admitted to hospital because of parenteral diarrhea or bacillary dysentery were treated with sulfathiazole in initial oral doses of 1 Gm. per year of age up to a maximum of 3 Gm., followed by the same daily amount divided in six doses. The alternate 14 patients were the controls. Six of the latter also received sulfathiazole late in their course. Except for the sulfathiazole, the treatment was the same in the two groups. The average time required for the stools to reach four a day of normal color and consistency was 3.2 days in the sulfathiazole-treated group and 15.6 days

in the control group. No deaths occurred in the sulfathiazole-treated group. Of the 14 controls, two died. In the sulfathiazole-treated group, the duration of diarrhea after admission bore no relation to the duration of diarrhea prior to admission; however, in the control group, recovery was later in those who had had prolonged diarrhea prior to admission.

It is concluded that sulfathiazole is effective in the treatment of children with parenteral diarrhea or bacillary dysentery, particularly the latter.—G. Taylor, M.D., J. Ped., 1941. (Clinical Abstracts.)

## TREATMENT OF GENERAL PERITONITIS OF APPENDICEAL ORIGIN

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This paper will deal with treatment only, omitting symptoms, signs and diagnosis.

The mortality rate from peritonitis of appendiceal origin, as reported in the literature,<sup>1</sup> varies from 6 per cent to 50 per cent, with an average rate of 20 per cent. Any steps that may reduce this mortality rate are worth considering. Following is an outline of the treatment which I have found successful in a small series of cases. The mortality rate is low and the period of hospitalization short.

### PREPARATION FOR OPERATION

As soon as possible after the diagnosis is made, the source of infection—the appendix—should be removed.<sup>2</sup> If the patient is dehydrated, parenteral fluids should be administered before operation. Glucose in saline is usually sufficient but if the plasma protein is low, a transfusion or plasma may be required. These patients require at least 3000 to 4000 cubic centimeters of fluid.

### DRAINAGE

In all cases, Wangenstein drainage should be instituted as soon as peritonitis is diagnosed. The tube, either Levine's or Miller-Abbott's, is introduced before or immediately after the operation. *Do not wait for distention* before beginning Wangenstein suction. Chief cause of distention is swallowed air. A patient recovering from an anaesthetic swallows much saliva and with it air. An early Wangenstein suction removes this saliva and air from the stomach, so that it will not be passed into the intestines where it causes distention in paralytic ileus. It is easier to prevent distention than to treat it, and much less exhausting to the patient.

### OPERATIVE TECHNIQUE

The choice of anaesthetic for the operation depends upon the ability of the anaesthetist.

1. Meyer, K. A., et al.: Acute appendicitis with perforative peritonitis. Illinois M. J., 76:221, Sept. 1939.

The type of incision depends upon the approach with which the operator is most familiar. Remove the appendix as quickly as possible with the least amount of trauma. Culture the peritoneal fluid. Use no gauze pads for "walling off" if possible. Suck out all the peritoneal exudate possible. Place a short cigarette drain to the appendix site. Deposit eight to twelve grams of sulfanilamide<sup>3</sup> in the peritoneal cavity. Close the peritoneum around the drain. Pack the remainder of the wound—muscle, fascia, fat and skin—open with vaseline gauze held in place by flamed adhesive strips.<sup>2,3,4,7</sup>

• The scope of this article does not permit a discussion of drainage of the peritoneal cavity, but a drain is of little value after twenty-four hours. To close the fascia and skin of a grossly contaminated wound is contrary to surgical principles. Each suture placed in the fascia carries bacteria further from the wound edges and microorganisms are locked in by closing the skin. The thick yellowish discharge that appears from the wound on the second or third post-operative day is from the abdominal wall, if the fascia and skin are closed. Wounds packed open do not have a thick discharge.

### POST-OPERATIVE ROUTINE

After operation the following regime is instituted. The patient is placed on his abdomen for from twelve to twenty-four hours. The drain will be of value for about this length of time, before the peritoneums will wall it off. Fluid will run downhill better than up, even though a wick is present. Drainage during this period is profuse in quantity and serosanguin-

9. Corry, D. C., et al.: Postoperative treatment of appendicular peritonitis with sulfanilamide and its derivatives. Brit. M. J., 1939, 2:561, Sept. 9, 1939.

2. Gamble, H. A.: The open treatment of peritonitis secondary to appendicitis. South. M. J., 29:834, Aug. 1934.

3. Cottis, G. W., and Ingham, H. W.: The non-drainage treatment of peritonitis. New York State J. Med., 35:1, Jan. 15, 1935.

4. Nassau, C. F.: Treatment of ruptured appendix. S. Clin. N. Am., Dec. 1937.

7. Bagen, J. A., and Dixon, C. F.: The management of peritonitis based on new concepts. Southwestern Med., Nov. 1935.



ous in character. At the end of twelve to twenty-four hours the patient is placed in a Fowler's position.

Morphine sulphate grains  $\frac{1}{4}$  is given every four hours unless respiration is depressed. Morphine<sup>5,6,7,8</sup> has a tonic effect on the intestines that helps reestablish normal peristalsis. The drug relieves the nervousness and apprehension which is so distressing to the patient, family and the doctor. It conserves the patient's strength to battle the infection. Morphine is continued for three days to three weeks at regular intervals and then as often as necessary.

#### OXYGEN INHALATIONS

Ninety-five per cent oxygen through a B. L. B. mask is given continuously for two to five days. The oxygen<sup>5</sup> decreases the general toxemia. The pasty gray skin becomes pink. Oxygen may reduce distention by altering the oxygen-nitrogen ratio in the alveolar air. Oxygen is absorbed from the air which gains access to the intestinal tract, thus leaving the nitrogen. If alveolar air is replaced with ninety-five per cent oxygen, the blood oxygen-nitrogen ration will be disturbed. The blood may absorb nitrogen from the intestinal tract to restore a normal oxygen-nitrogen ratio. After two days, if the patient is doing satisfactorily, the oxygen is discontinued for intervals of one or two hours and finally stopped.

#### HYDRATION

Continuous intravenous fluids are given. Five per cent glucose in saline is alternated with 10 per cent glucose in distilled water. Approximately 5000 cubic centimeters a day are required. While the patient is on his abdomen, this is given in a vein on the dorsum of the hand or wrist. After placing the patient in Fowler's position, the fluids are given by venoclysis in the leg. This allows the patient free

use of his arms and he can be moved or turned with no discomfort. The amount and type of fluid are judged by plasma protein determinations made once or twice a day. This measurement also indicates when blood plasma or a transfusion should be given. These fluids are the total intake of the patient as the Wangensteen suction keeps the stomach empty.<sup>1</sup> The Wangensteen suction is not closed at all for the first forty-eight hours. If then the patient's course is favorable it is closed for short periods of time. When the amount of drainage in the Wangensteen apparatus is less than the fluid intake by mouth and there is no distention, the suction is discontinued. This is usually the fourth or fifth day.

#### OTHER MEASURES

Rectal discomfort is relieved by a rectal tube. No enemas are given until the third, or preferably the fourth day, as an enema stirs up the intestines which tends to aggravate the peritonitis. Prostigmin and similar drugs are not used for the same reason. If treatment is started early, there is no distention requiring enemas or prostigmin.

Packing in the wound is loosened and part of it is removed each day until it is all out on the fifth to seventh day. The drain is removed on the fourth or fifth day. The wound edges are drawn together with long pieces of flamed adhesive. It is completely healed in three to four weeks. The scar is thick, dense and firm, not more than one-quarter inch in width.

#### RESULTS

With this treatment the patient has no nausea or vomiting, no distention, no anxiety, no marked dehydration and no gas pains. The general condition is remarkably good. The patient is out of bed and home early. Most of the cases are discharged within twenty-one days after the operation. Two patients left the hospital on their fifteenth and sixteenth post-operative days, respectively. No single factor cures these patients. It is the total regime that helps them throw off their infection.

5. Orr, T. G.: A rational treatment of acute peritonitis. *South. Surgeon*, 2:102 (1933).

6. Orr, T. G.: Action of morphine on the small intestine and its clinical application in the treatment of peritonitis and intestinal obstruction. *Ann. Surg.*, 98:835 (1933).

8. Burden, V. G.: Postoperative management of appendiceal peritonitis. *Am. J. Surg.*, 12:294, May 1931.

## THE TREATMENT OF THE INFERTILE PREGNANT PATIENT\*

## MATERNAL WELFARE ARTICLE NUMBER SEVENTY

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Despite the fact that the past year has seen an astonishing increase in birth rate throughout the country, it is doubtful that we are returning to the day of large families. The exigencies of economic life, city dwelling, and the expense of raising a family make this highly improbable. At one time it was quite to be expected that a woman might lose her first gestation in difficult labor, and that she might have a number of miscarriages during the course of her child-bearing experience and still do a creditable job of family bearing. Now it is considered somewhat a reflection upon the attending physician if the fetal life is lost during parturition; and the patient is not at all loathe to change physicians, even in the case of spontaneous miscarriage. Thus, the life of the individual baby has become increasingly more valuable, and the preservation of individual pregnancy of greater importance.

These considerations have given rise to the present widespread interest in maternal welfare, and the lessening of maternal and fetal death rates; and, in recent years, an added impetus to the study of the causes of prematurity, of stillbirth, of miscarriage, and of sterility.

At first consideration, this topic—The Treatment of the Infertile Pregnant Patient—may seem somewhat ambiguous, the term “infertility” having sometimes been employed to indicate entire failure to conceive. We are invoking the term “infertile”, however, in its broadest interpretation to include not only the patient who is sterile, but also those who have either had periods of relative sterility, or previous obstetrical experience without issue. One might describe such a patient as being unsuccessful or inefficient in her reproductive physiology. In this classification we would

place those who for one reason or another have been barren for a number of years before conception, those whose previous pregnancies have terminated in fetal death from such causes as toxemia or labor dystocia, those who have failed in issue because of fibromyomata complicating pregnancy, those who have suffered habitual abortion from endocrine or other disturbances, and finally, a considerable group of patients who have experienced abortion from miscellaneous and obscure causes.

As material for this discussion we have pulled from the files of private practice a group of forty-eight histories of patients encountered during the past five years, who in one way or another, accord to this classification and whom we have been able to follow more closely than is practicable in a larger series of ward cases. It is our purpose to discuss how these cases have been managed, and to consider from the clinical point of view the value and efficacy of some of the measures employed.

## TOXEMIA OF PREGNANCY AND INFERTILITY

One of the most frequent causes of stillbirth and neonatal mortality, as evidenced in our studies in the Stillbirth Committee of the Philadelphia Obstetrical Society, is *toxemia of pregnancy*, the term “toxemia” being employed in its broadest sense as representative of all those cases which display elevation of blood pressure, with or without edema and albuminuria. This problem has particularly interested us at the Temple University Hospital and we have had an opportunity to observe the results obtained with dehydration therapy as developed at that institution.

As we observed the cases admitted to the wards there, and reviewed the histories of some thirteen patients from our own files, we became impressed with the following facts:

\* Read before the Section on Obstetrics and Gynecology of the Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 22, 1942.

first, how few instances there are of what we used to call true preëclampctic or eclampctic toxemia; and how relatively many cases with pre-existing vascular damage of slight or moderate extent developed so-called "toxemic" manifestations in the latter part of pregnancy. Among this small group of the patients of one of us there is only one patient who accords to the picture of fulminating eclampctic toxemia. This patient developed a series of minor eclampctic convulsions, three in all, following delivery. Her highest systolic pressure was 128 and the albuminuria developed during the labor. All of the others either gave a history of some predisposing illness such as scarlet fever, or showed early in pregnancy mildly elevated blood pressure, particularly of the diastolic pressure, probably indicative of slight vascular disturbance. The second observation which we consider of importance in this group is the profoundly important effect which dietary control has in preventing the development of significant symptoms in the essential hypertension group. For example, there were two patients in our group who had had very definite and disturbing signs of toxemia at the fifth and sixth months respectively in previous pregnancies. In one of these, abruptio placenta had occurred, and in the other, a Cesarean section was performed at the 32nd week in order to salvage maternal and fetal life. In each of these instances, with careful dietary control, the patient carried to term two subsequent pregnancies with normal issue and without toxic manifestation.

By "careful dietary control", we mean the provision of an ample protein intake to maintain plasma protein level, and to satisfy the nitrogen requirements of the mother and the developing fetus. Such a diet also must furnish adequate quantities of calcium, iron, and of the vitamins A and D. I think we will all confess that in years past we have literally *starved* the obstetric patient, and such starvation was an important element in the production of edema, albuminuria, and the so-called toxemia of pregnancy.

Speaking of the subject of diet in toxemia, may we call your attention to two important presentations that have been made during the

past year. One comes from the medical department of the University of Toronto, as a thorough study on the nutrition in pregnancy by Ebbs, Scott, Tisdall, Moyle and Bell, and another by Dr. Winslow Tompkins from the Lying-In Hospital in Philadelphia. Both studies emphasize the importance of adequate diet, both in the health of the mother and in the growth and development of the fetus. Both indicate a significant lowering of the toxemia rate in the carefully controlled and properly fed patient. In fact, Dr. Tompkins goes so far as to state that he has not seen toxemia develop in any of the patients that have been under dietary supervision. The Canadian report is of particular interest because the investigators were able to provide every other patient with the proper food essentials to bring the dietary up to an adequate level. This adequate level they present as follows: A daily caloric intake of 2400 to 2800, protein of 80 to 100 grams, fat from 80 to 100 grams, carbohydrate 350 to 400 grams, calcium  $1\frac{1}{2}$  grams, iodine in iodized salt, vitamin A—6000 Int. units, vitamin B<sub>1</sub>—500 to 100 Int. units, vitamin B<sub>2</sub>—3 to  $3\frac{1}{2}$  Mgms., vitamin C—50 to 75 Mgms., and vitamin D—500 to 1000 units.

After having provided certain of the patients with additional food supply to bring their intake up to a level of adequacy, comparative studies were made of this group with the controls. The improvement in the prenatal condition of the properly fed patient, in her reaction to labor, and her recovery after delivery, were astonishing. Even more startling were the results achieved in the offspring—lessening in the number of abortions, miscarriages, prematures, and stillbirths. In summing up the results, the authors state that 34 per cent of the pregnancies ended in a poor or bad fashion in the *insufficient* diet group, while only six per cent ended in an unsatisfactory fashion in the *supplemented* diet group.

In addition to dietary measures in the handling of these "toxic" patients, we have also routinely employed either wheat germ oil, or vitamin E in the form of alpha-tocopherol. How much of a part the vitamin E has played in the favorable results we cannot say. We



have further remarks to make on this subject. The good results obtained we believe are attributable largely to diet, limitation of salt and fluid intake in the face of edema, and the careful selection of the time and type of delivery. Three of these patients were delivered by abdominal Caesarean section under local anesthesia; three had medical or surgical induction before term, and the remainder were carried to full term with vaginal delivery.

#### ENDOCRINE DISTURBANCES IN PREGNANCY

We have little to add at present on the management of the endocrine patient in pregnancy. Much has been written on this subject, and the more that the volume of literature accumulates, the more confused are we as to the true issues. Among our small group of patients we find thirteen that have been listed as endocrine problems. As we look back over the favorable results that have been achieved in a number of these patients we are at a loss to know which of the methods of treatment employed have really contributed to a successful termination. All of them have had wheat germ oil or vitamin E. Practically all of them have had injections of progesterone. Over half of them with low normal thyroid rates have taken thyroid extract. All have had longer or shorter periods of rest in bed.

Sufficient evidence has accumulated over a long period of time to convince us that thyroid extract is the most potent product of internal secretion that can be administered during pregnancy, and that more of favorable results have followed its usage, where indicated, than any other endocrine preparation. Since the recognition of hypothyroid states is not always easy, the question arises whether it might not be better to give minimal doses of thyroid extract as a routine procedure. For all patients this is not acceptable, inasmuch as some patients will develop headache and palpitation after continued administration of even small amounts. In a recent contribution on this subject Winkelstein points out the efficacy of thyroid extract in sterility due to hypothyroidism, and the complete lack of efficacy of this drug in sterile patients who do not have a definite hypothyroid disturbance. It would seem bet-

ter in pregnancy to limit thyroid medication to those patients either with a lowered metabolism or with other clinical evidences of thyroid deficiency.

When it comes to the question of progesterone therapy, there is still great difference of opinion. The clinical reports are contradictory and difficult to assay. Laboratory studies were based upon a determination of the degradation products of progesterone; the true determination of effects and results must wait upon more accurate methods of study. Hamblen presented a recent study in which clinical methods were combined with careful laboratory observations. Hamblen's results have been mentioned in Dr. Carrington's report, but I think the conclusions which were reached might well be repeated. (See July 1942 Maternal Welfare Article.)

We have used progesterone freely in the treatment of threatened and habitual abortion, and from clinical observation, we are rather convinced of the following facts: first, that the use of a so-called maintenance dose of one-half or one milligram, once or twice a week, is of questionable value; second, that large doses of progesterone, five milligrams or ten milligrams, are useful in quieting the uterus when miscarriage or premature labor are threatened—particularly useful, we would say, from the third or fourth month onward. Our practice in the future will be to limit the use of the drug to single or concentrated dosage in large amounts in the face of an irritable and contracting uterus.

The efficacy of wheat germ oil in the treatment of the infertile pregnant patient is also problematic. Careful studies would indicate that the average American diet contains adequate amounts of vitamin E, and that the addition of further vitamin E is wasted. On the basis of the early reports we began administering wheat germ oil a number of years ago, using at first the Canadian preparation—viteol. At first we prescribed it only in threatened abortion. Later we began using the wheat germ oil in all patients who presented a suggestion of endocrine disturbance or stigmata, and finally, during the past six months and since the introduction of the alpha-tocopherols

we have been administering vitamin E to every pregnant patient during the first three months. The most interesting observation of results following the generous feeding of vitamin E is the fact that during the past eight weeks we have had among these same patients five spontaneous abortions with no evident etiological factor. This experience has convinced us that our previous favorable observations were probably fallacious, and that in the average patient, the administration of the vitamin is not advisable. Frankly, we doubt that it has played a very important part in the treatment of the toxemic patients either.

There is one measure of treatment which in our minds stands out in importance above all other therapeutic agents in the treatment of the endocrine patients with the threatened abortion and in habitual abortion, and that is rest in bed plus the maintenance of a quiet environment. We think there are many abortions incited by physical exhaustion, emotional disturbance, nervous excitement, coitus, unnecessary shopping expeditions, motor trips, etc. It is quite true, of course, that there may be also a low threshold for abortion in these cases. Nevertheless when the additional inciting factors are eliminated, the prospects of carrying the pregnancy to term are improved. For the patient who has a threatened abortion, or any tendency in that direction, we eliminate visits at the office and insist upon the patient remaining at home until the pregnancy is firmly anchored and well on its way. The most dramatic results which we have had are in the patients who have remained in bed for periods of four to six months and have had their prenatal care conducted at home.

In the case of endocrine disturbance we generally accomplish more when we have a chance to study the patient before she is pregnant and to carry out preparatory treatment. Such preparatory treatment consists of the determination of basal metabolism and administration of thyroid if necessary, the determination of levels of anterior pituitary and estrogens and the administration of gonadotropins as indicated. In these cases we do not encourage the attempt to become pregnant until a reasonably normal menstrual cycle is established. In this direc-

tion we have reasonably good success with preparations of the pregnant mare's serum. Once a reasonably normal endocrine balance is established and the field in the uterus for implantation of pregnancy is properly prepared, the chances of a sustained normal gestation are much improved.

#### FIBROMYOMATA AND INFERTILITY

Fibromyomata of the uterus complicating pregnancy constitutes a problem of increasing importance as the age of marriage and age of childbearing become more advanced. The fact that many women do not attempt pregnancy until the early thirties brings them into that period of life when fibromyomata of the uterus begin to manifest themselves and when these growths assume such size as to complicate the pregnancy and labor. In our group of personally observed cases, there are ten in which fibroids constituted a major complicating factor. In three of these, previous miscarriages had occurred.

In general, the problems of management of the pregnancy have to do with those same principles which apply in threatened or habitual abortion. They involve the institution of rest, and the administration of various drugs and endocrine preparations to quiet the uterus. In most cases, this conservative plan of therapy suffices to carry the patient to the period of fetal viability. Occasionally, however, one has to remove a growth which has impinged so extensively upon the pelvic chamber and the pregnant uterus as to make continued pregnancy impossible. In one of these cases we performed a myomectomy at the third month of pregnancy and the gestation continued to full term with spontaneous outcome. In two instances, the pregnancy was complicated by retroversion and impaction of the pregnant uterus in the hollow of the sacrum. The manual replacement under gas anesthesia was successful in one, and in the other, it was necessary to perform a laparotomy at the twentieth week. In the later case a simple replacement of the uterus was performed and the fibroid was not disturbed because of its position in the cervix. At term the cervical fibroid interfered with the engagement of the head and it was

necessary to perform an abdominal Caesarean section. In view of the age and multiparity of the patient the uterus was also removed.

Two patients, including the one just described, had abdominal hysterotomy and hysterectomy at term because of the presence of fibroids interfering with labor, and of the fact that the patient was a multipara of advanced years. In a third case, Caesarean section was performed and was followed immediately by myomectomy. Such a procedure is feasible when the myoma is definitely subserous, and is quite easy where the tumor is pedunculated. In three patients myomectomy was performed either before the pregnancy or immediately afterward in order to enhance the fertility of the individual in subsequent gestations. In one of these, because of the extensive nature of the myomectomy, elective abdominal Caesarean section was performed at term.

There are no very definite rules that can be laid down on the subject of fibromyomata in pregnancy except that conservative practice should prevail until the tumor impairs the health of the mother or child. Each case is a law unto itself and offers individual problems in the consummation of the delivery and in the ultimate disposal of the tumor.

#### PREVIOUS DIFFICULT DELIVERIES WITH DEAD BABIES

Every obstetrician encounters the patient who has had some unfortunate obstetric experience elsewhere and who changes physicians, not because of any valid criticism of what has been done, but in the hope that her luck will be better with the next man. There are six of these patients which we have recorded and each of them had lost one or more babies at full-term delivery—some by primigravida breech delivery and some by misjudgement as to disproportion. All of the unfortunate incidents were such as might happen to any one of us.

This group offers no very great problem other than that presented by the patient with a moderately contracted pelvis or a disproportionately sized fetus. In view of the previous history of disaster, it is a great temptation to perform in each such case a Caesarean section

on the assumption that fetal death having occurred once the possibility of its occurring again should be thus certainly prevented.

This point of view, I think, is poor judgment because the chances of a patient having a normal living child are better, having passed a previous labor. If one can be assured from their clinical studies and x-ray examination at term, that no actual disproportion exists between the fetus and the pelvis, then the obstetrician should stick by his guns and let the patient start in normal labor with the expectation of consummating a vaginal delivery. Actually, this was done—with success—in five of these patients. The sixth patient showed frank evidences of disproportion and a Caesarean section was performed.

#### MISCELLANEOUS UNFRUITFUL PREGNANCIES

The group of patients in which we have had the greatest difficulty are those in whom no obvious cause for abortion has been present and in which during the examination and conduct of the pregnancy, no reason has appeared for anticipating an unfruitful termination. In the first pregnancy at least, this group of patients is conducted as in any other normal pregnancy. One is astonished to have the patient call and say that she is bleeding and having abdominal cramps. Often despite one's best efforts the patient goes on to an inevitable or complete abortion. In subsequent pregnancy, of course, one is put on their guard for no other reason than the patient having had previous trouble.

In this group of miscellaneous cases, we have 17 patients recorded who had previous abortions, either under our own supervision or under that of someone else, and for which there was no evident cause. In five of them the early replacement of the uterus from a retroverted position, and support with a pessary, seemed to facilitate the course of subsequent pregnancies, and in the others the insistence upon a more quiet type of existence, periodic rest and sedation, were successful in carrying the pregnancy to term.

Of course, one must recognize that in such a group there are quite a number of abortions which have nothing to do with maternal activi-



ties or abnormalities. Such are cases in which the embryo is either abnormal to start with, or is implanted at an unfavorable level in the uterus. Under such circumstances no known method of treatment will prevail.

#### BLEEDING IN THREATENED ABORTION

There is one point that we would like to make concerning threatened abortion in general, and that is the amazing amount of bleeding which may sometimes occur, and the prolonged bleeding which may sometimes be encountered, without actual interruption of the pregnancy, and without impairment of the embryonic life. We cannot agree that bleeding *per se*, even a considerable amount of it—over a long period of time, is always an indication for interruption of the pregnancy, or that one can assume on the basis of it that abortion is inevitable. On this point we feel very strongly, for there are several patients in this series in whom bleeding occurred intermittently throughout pregnancy, and at times to quite an extensive degree, and yet the patients were delivered at term of quite lovely normal babies.

The criteria upon which we base our indications for interference are the changes in contour of the uterus and cervix. By changes in contour we refer to the ballooning out of the cervix, effacement, with or without some dilatation of the external os. This phenomenon, along with excessive bleeding, indicates that the anchorage of the chorionic villi have been disrupted and the products of conception are now lying detached and loose in the lower uterine segment. In such cases, prompt evacuation, or steps toward the evacuation of the uterus are definitely indicated. Where bleeding is intermittent and repeated, the change from a positive Friedman to successively negative Friedman test is indication that the embryo has died and that the products of conception are being harbored unduly long in the cavity of the uterus.

We agree with Shute that the idea that in a threatened abortion the embryo will be abnormal is a misconception of fact. We have carefully reviewed our records of full-term deliveries following threatened abortion and find only one or two instances where a spina

bifida or anencephale has occurred, a frequency not much greater than one encounters in perfectly normal pregnancies.

Finally, we have handled 76 pregnancies in these 47 patients, who for one reason or another were relatively infertile. Fifty-eight of these have terminated successfully with living issue; five are under our care now for another pregnancy.

#### SUMMARY

To summarize these observations:

1. The modern dietary control of pregnancy has contributed more than any other factor to the elimination of preëclamptic manifestations as a common cause of unfruitful pregnancy.
2. We have no dependable agent other than thyroid extract in the treatment of threatened abortion or habitual abortion due to endocrine disturbance, and in this situation we have found progestin of value only in large dosage and when administered as an agent to quiet excessive uterine contractility.
3. We question the efficacy of vitamin E, having reason to believe that most diets contain an ample quantity of this vitamin.
4. That rest and a serene environment are still important items in a regimen of treatment.
5. We find fibromyomata complicating pregnancy to be an increasingly important factor in infertility. The increased frequency of this factor is due to the advancing age at marriage, and the consequent occurrence of more pregnancies in this age period. This group offers many individual problems in management which tax the ingenuity and operative skill of the attending physician.
6. That the conduct of pregnancy and labor subsequent to previous dystocia with dead fetus again presents the old problem of management in disproportion, except for the fact that a woman who has once had a vaginal delivery will usually perform more successfully in a subsequent one.
7. Among the miscellaneous group of miscarriages we are still faced by the unexpected abortion of unexplainable cause. Many of these doubtless are the result of some innate

disturbance in the development of the embryo or its attachment.

8. We caution against accepting bleeding

alone as an evidence of inevitable abortion or as an indication *per se* for evacuation of the uterus.

2031 Locust Street

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## A LESSON FROM A DEATH CERTIFICATE

### NUMBER FORTY-ONE

Patient two and one-half months pregnant. History of previous cesarean for placenta previa. Sent to hospital for therapeutic abortion, reason unknown. Hysterectomy done. Reacted well but in evening suddenly became cyanotic and died.

Regardless of the cause of death, some of us feel that a hysterectomy is a serious operation in order to induce a therapeutic abortion.

A. W. BINGHAM, M.D.

## ARTIFICIAL INSEMINATION

That artificial insemination is much more widespread than is commonly believed is revealed in a report in *The Journal of the American Medical Association* by Frances I. Seymour, M.D., and Alfred Koerner, M.D., on the results of a recent survey.

"Thirty thousand physicians in this country were circularized. Seven thousand, six hundred and forty-two replies were received. These bore witness to the fact that 9,489 women had achieved at least one pregnancy by this method. Almost two-thirds of all the successful pregnancies were effected through the use of the husband's semen alone.

"More than 97 per cent of all the pregnancies resulting from artificial insemination terminated in living, normal babies. The remainder included 217 miscarriages and abortions, this incidence being only one-fifth or less than that among normal women in whom pregnancies result without aid. . . .

"Artificial insemination was employed so successfully that in 1,357 patients more than one pregnancy was effected by this means. The grand total of children sired by the method and here reported is nearly 9,500. . . .

"A fair appraisal of artificial insemination can be obtained only after careful and controlled work. One hundred per cent success is not expected from any method, not even from artificial insemination, especially when one's efforts are abandoned after one to six attempts at insemination. . . .

"A three-year period with an average of three inseminations a month should be established, since that would be twice as long as is allowed for unaided pregnancy before the couple is considered sterile."

The authors estimate that nearly 400 surgical operations were prevented by the use of artificial insemination.

## STATE ACTIVITIES

## TO OUR MEMBERS SERVING IN THE ARMED FORCES

The idea of the following letter was proposed by Dr. Wells P. Eagleton. It is being sent in the name of the President who was in office at the time of our last Annual Meeting, and the President now in office, with the approval and endorsement of the Board of Trustees, to show the interest of The Medical Society members in their colleagues now serving in the armed forces.

Dear Dr. Smith:

The Medical Society of New Jersey wishes to express its appreciation of your patriotic sacri-

fice in having abandoned your practice for service with the armed forces of the United States. The Society considers it a privilege to remit your dues for the current year and expresses the hope that this practice may be continued for the duration of the present emergency.

We, the Officers, wish you to be cognizant of the fact that we have a personal interest in your welfare. Feel free to communicate with any of us personally or through the Executive Offices, 143 East State Street, Trenton.

Sincerely yours,

THOMAS K. LEWIS, M.D., President;  
ELIAS J. MARSH, M.D., President-Elect.

MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON  
ACTIVE DUTY IN THE ARMED FORCES

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

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## SUPPLEMENTARY LIST OF MEMBERS NO. 2

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Denholtz, Emanuel, 16 Harrison pl., Irvington (7)  
DiIelsi, Anthony J., 1013 South 5th st., Camden (4)  
Flax, Ira I., 890 South 16th st., Newark (7)  
Fortunato, Joseph F., 224 Van Buren st., Newark (7)  
Gebirtig, Theo., N. J. State Hosp., Greystone Pk. (14)  
Greenwood, Samuel B., 190 Clinton av., Newark (7)  
Harman, Byron M., Essex Mt. Sanatorium, Verona (7)  
Hawke, Edward K., 113 Main st., Newton (19)  
Hays, Roy G., 567 Haddon av., Collingswood (4)  
Holey, Barth, 15 N. 6th ave., Highland Park (12)  
Jackson, Elmer C., Blair Academy, Blairstown (7)

Marvel, Philip, Jr., 101 S. Indiana av., Atl. City (1)  
Motzenbecker, William J., 16 Milford av., Newark (7)  
Pinsky, Harry A., 944 South 5th st., Camden (4)  
Reinfeld, Abraham G., 354 Clinton av., Newark (7)  
Rogers, Richard M., 129 S. Munn av., E. Orange (7)  
Rosenthal, Abraham, 43 3rd av., Atl. Highlands (13)  
Russell, Edward W., 801 Cooper st., Camden (4)  
Scott, Karl M., 1616 Pacific av., Atlantic City (1)  
Sellitto, A. M., 115 Connett pl., So. Orange (7)  
Wesson, Harrison R., 15 The Crescent, Montclair (7)  
Whitken, Albert I., 1056 North av., Elizabeth (20)  
Wilson, Isam E., 110 Chapel av., Merchantville (4)  
Yadkowsky, Emanuel, 637 High st., Newark (7)  
Zimmerman, Robt. F., 28 W'shingt'n av., Morristown (14)

### ASSOCIATE MEMBERS

Ravitz, Israel, 56 Montgomery st., Bloomfield (7)  
Spence, Harold G., 205 Watchung av., Up. Mtclair. (7)

## OPIFERQUE PER ORBEM

"I am called Help-Bringer throughout the world" is the translation of the inscription which appears in Latin on the seal of The Medical Society of New Jersey. Strangely enough, but quite appropriately, this inscription is a part of a lover's assurance that he is and should be regarded as a friend and not as an enemy. Our President ran across this inscription and its translation in a volume of The Loeb Classical Library titled Ovid Metamorphoses (vol. 1), published by the Harvard

University Press of Cambridge, Massachusetts (pages 38, 39). Dr. Marsh presented to the State Society a copy of this book and it is respectfully called to the attention of the officers and members of the Component County Medical Societies in the belief that they might wish to obtain a copy, either individually or collectively. The members of the medical profession are lovers of mankind and are truly known as "bringers of help throughout the world".

## ADULTERATION OF "DOPE" PEDDLED IN ILLICIT TRAFFIC

By the time the drug reaches the addict, much of it is less than one per cent pure. The average percentage of adulteration of heroin found in illicit traffic in 1938 reduced the heroin content to 27.54 per cent. In 1939 the heroin content was only 9.63 per cent, and in 1940 it averaged only 3.31 per cent purity.

Adulteration in varying degrees has been found in the morphine, heroin, and cocaine sold in the illicit traffic. Two hundred twenty-eight separate

chemical analyses of morphine seizures, 1,836 analyses of heroin seizures, and nine analyses of cocaine seizures were made during the calendar year 1940 to determine the percentage of purity, and it was found that the morphine ranged from less than one to 100 per cent pure; heroin from less than one to 100 per cent pure; while cocaine ranged from 63 to 68 per cent pure. The average percentage of purity was 69.33 per cent for morphine, 3.31 per cent for heroin, and 97.12 per cent for cocaine.—Courtesy, Federal Bureau of Narcotics.

## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

The following list covers April, 1942:

CAMPBELL, MEREDITH F. (Montclair and New York), and MATTHEWS, WILLIAM F. (Montclair)

Renal thrombosis in infancy, report of 2 cases in male infants urologically examined and cured by nephrectomy at 13 and 33 days of age. *J. Pediat.* 20:604-615, May 1942

GARNER, JAY M. (Trenton)—See Pessel, J. F.

GOLDMAN, LESTER M.; KESSLER, HENRY B., and WILDER, MILDRED E. (Newark)

Colostrum cutaneous test for the diagnosis of pregnancy. *J. A. M. A.* 119:130-132, May 9, 1942

GOLDSTEIN, HYMAN I. (Camden)

Congratulations to Dr. Max Einhorn on his eightieth birthday. *Am. J. Digest. Dis.* 9:85-86, Feb. 1942

GORDON, BENJAMIN LEE (Atlantic City)

Medicine among the ancient Hebrews. *Ann. M. Hist.* 4:219-235, May 1942

GORDON, MAURICE B. (Atlantic City)

Popular medicine in Sasanian Babylonia. *Ann. M. Hist.* 4:241-245, May 1942

KESSLER, HENRY B. (Newark)—See Goldman, Lester M.

KILDUFFE, ROBERT A. (Atlantic City)

1. Disease and destiny. *Mil. Surg.* 89:851-856, Dec. 1941

2. The next great plague to go. Being a short history of syphilis. *Mil. Surg.* 90:374-386, April 1942

KRAEMER, MANFRED (Newark)

Serum coagulation reaction: its clinical significance. *Am. J. Digest. Dis.* 9:127-132, April 1942

MATTHEWS, WILLIAM F. (Montclair)—See Campbell, Meredith F.

MCCRAY, PAUL, JR. (Camden)

Simple apparatus for the administration of pentothal sodium oxygen anesthesia by one ointment. *Am. J. Surg.* 56:517, May 1942

NESSELROD, J. R. (Trenton)—See Pessel, J. F.

PESEL, J. F.; GARNER, JAY M., and NESSELROD, J. F. (Trenton)

Proctoscopic cinematography. *Am. J. Digest. Dis.* 9:140, April 1942

ROEMER, MILTON I. (Paterson)

History of the effects of war on medicine. *Ann. M. Hist.* 4:189-198, May 1942

SHERMAN, A. RUSSELL (Newark)

Crystalline dystrophy of the cornea. *Arch. Ophth.* 27:692-695, April 1942

WATERS, EDWARD G. (Jersey City)

Weight studies in pregnancy. *Am. J. Obst. & Gynec.* 43:826-832, May 1942

WILDER, MILDRED E. (Newark)—See Goldman, Lester M.

## NEW JERSEY CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The New Jersey Chapter of the American College of Chest Physicians is one of the newer groups with specialized interests and services. This organization provides opportunity for the physicians interested in chest conditions—dominantly tubercular in the case of the chronic diseases needing prolonged institutional care—to keep up to date through the effective method of exchange of experience and criticism of a constructive type.

At a meeting held on April 22 at Haddon Hall in Atlantic City there were fifteen in attendance. These were largely directors of

tuberculosis institutions, among whom was Dr. Marcus W. Newcomb, Governor of the College, who urged continuation of the New Jersey Chapter and more frequent meetings.

Dr. Julian Johnson, Director of the Department of Thoracic Surgery, University of Pennsylvania Hospital, Philadelphia, presented a very interesting and constructive talk on total pneumonectomy, which was illustrated.

The following officers were unanimously elected: President, Dr. Joseph Morrow; Vice-President, Dr. Clyde N. Fish; Secretary-Treasurer, Dr. Paul K. Bornstein.



## NEW LEGISLATION ON HERNIA

On May 2nd Senate Bill No. 55 became Chapter 97 of the Revised Statutes. This Bill, supported by The Medical Society of New Jersey, had for its purpose the removal of the \$150 maximum fee for combined medical and hospital care of hernia cases under the Workmen's Compensation Act.

The passage of this act is further evidence that the support of the Legislators can be obtained in the majority of cases when Organ-

ized Medicine has a just grievance and presents its claims through its Legislative Committee and County Keymen.

A year-round contact between our County Society Keymen and their respective Legislators is an integral part of a state-wide plan. This plan has been developed by our Subcommittee on Legislation, and it embraces the co-operative action of the County Societies, which is the basic essential in such a plan.

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## OBITUARIES

### DR. EUSTACE BUTLER

Dr. Eustace Cameron Butler, dean of Caldwell physicians and head of a private hospital there since 1915, died at his home in Park Lane, Essex Fells. Dr. Butler, who was 60, died of a heart attack on May 12, 1942.

Dr. Butler had practiced in Caldwell since 1910, four years after his graduation from the College of Physicians and Surgeons of Columbia University. For a short time before starting his hospital he maintained an office in Caldwell. Born in Nassau, Bahamas, Dr. Butler attended Queen's College there before coming to the United States. After graduating from Columbia he interned in several New York hospitals before going to Caldwell.

Dr. Butler was a Fellow of the American College of Surgeons, a member of the Essex County and State Medical Societies and the American Medical Association. He was on the staff of Overbrook Hospital. He also practiced surgery in Passaic General Hospital.

A 32d degree Mason, Dr. Butler was a member of Caldwell Lodge 59, F. and A. M. His clubs were the Fells Brooks Club, of which he was a charter member, and the Caldwell-West Essex Kiwanis Club. He also was a former and charter member of the Newark Athletic Club and the Essex Fells Country Club.

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### DR. PETER B. DAVENPORT

Dr. Peter B. Davenport, a physician in Newark for 43 years, died on March 7, 1942, in Dr. Loux's Hospital near Sussex. Dr. Davenport, who was 70, was born in Colesville, Sussex County. In 1897 he was graduated from New York University Medical School. After serving a year at Bellevue Hospital, he started practice in the Vailsburg section. He was active in Masonic circles and on February 20, 1941, was honored on his 50th anniversary as a Mason. He was a member of Century Lodge, South Orange.

During World War I, Dr. Davenport served as a medical officer for draft boards, a function he continued in the present war until his retirement in October.

Dr. Davenport was a member of the Essex County and State Medical Societies and the American Medical Association.

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### DR. FRANK S. HARGRAVE

Dr. Frank S. Hargrave, practicing physician and Essex Assemblyman serving his ninth term since 1929, died on March 11, 1942, at his home in Orange. Dr. Hargrave, an outstanding Negro leader, was 60 years old.

Dr. Hargrave was born in Lexington, N. C. He was graduated from the Shaw University Medical School and the Leonard School of Medicine, and practiced for a time in Raleigh, N. C. He took an active part there in establishing a new hospital. He left Raleigh 18 years ago to establish his practice in Orange.

Dr. Hargrave was first elected to the Assembly in 1929 and was returned eight times. In the Assembly he was a leader in public health matters and was chairman of that committee in 1936, 1938, 1939 and 1940. He organized much health legislation during his service, and also was chairman of a commission to report on culture, health and living conditions of urban Negro populations. Dr. Hargrave was most helpful in the legislation which met approval by The Medical Society of New Jersey, and his interest and support was recognized and appreciated by his professional colleagues and the public he served.

Dr. Hargrave was a former President of the National Medical Association and the first President of the New Jersey Colored Republican League. He was a member of the North Jersey Medical Association and was active in the New Jersey Tuberculosis League. Dr. Hargrave was a deacon of the Union Baptist Church of Orange and superintendent of its Sunday School.

## ● THE BULLETIN BOARD ●

At the Annual Meeting of the Radiological Society of New Jersey on April 22, 1942, the following officers were elected:

President: Dr. W. James Marquis, Newark  
Vice-President: Dr. H. Austin Vogel, Elizabeth  
Secretary: Dr. Harry J. Perlberg, Jersey City  
Treasurer: Dr. Charles Oderr, Westfield  
Counsellor: Dr. Clarence A. Plume, Succasunna

### ● ● ● GRANTS FOR STUDIES ON INFANTILE PARALYSIS

Under the date of April 1st, 1942, The National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York City, issued a statement regarding its policies governing the making of grants and its rules governing its grants, with especial emphasis on the personnel aspects. Copies may be had upon request by those interested.

"Grants ordinarily are made to an institution and not to an individual. \* \* \* Applications from qualified scientists will, however, receive thorough consideration."

Applications are considered semi-annually and are for one year beginning *January 1st* or *July 1st*. These applications must be on file in the office on or before *March 1st* and *September 1st*.

### ● ● ● PARERGON

#### "WORK BY THE SIDE OF WORK"

This superbly presented collection of the artistic contributions of physicians is issued periodically by Mead Johnson and Company, Evansville, Indiana, and the latest copy has just been received in the Executive Offices in Trenton. There are 96 pages of etchings, sculpture, paintings, lithographs, photos, block prints, wood carvings and ceramics which represent the avocational interests of physicians throughout the country and show the versatility of many of our colleagues who find relaxation and diversion from their medical work in the creative arts, and contribute thereby to the cultural aspects of their generation and to the wider interests of those who appreciate the latent abilities of those of the profession who will take time to develop these aptitudes and skills for their own satisfaction and the appreciation of those with kindred interests. May

this collection stimulate more physicians in need of the refreshing influence which comes from such efforts to "go and do likewise".

### ● ● ● FELT

Many new uses of interest to physicians is now being made of wool-felt. It is an excellent "isolator" of vibrations which are injurious to delicate instruments as well as to injured patients.

It can be sterilized and used in surgical appliances, in diathermy as "pads"; is unalterable in character; is not easily inflammable; will absorb moisture, or per contra will hold it to supply an adjacent part for medicinal purposes. It is available in any density. Ambulances as well as armored tanks employ felt to minimize vibration and it is used in the armour worn in modern mechanized war vehicles. Truly great is the stimulus given to our inventive genius by the urgency of war demands.

### ● ● ● A NEW FILM OF INTEREST TO PHYSICIANS

At the Academy of Medicine in the final week of May, before a gathering of 500 physicians and surgeons, a new film called "Sutures since Lister" was shown by Johnson and Johnson (New Brunswick). The film briefly compares the early methods with the present aseptic precautions to insure protection against infection and secure the surgical purpose for which the sutures are intended.

A complete picturization of the processes through which the suture materials pass before they are offered to the surgeon is shown. The process extends from the time the sheep intestines are obtained until the finished suture reaches the operating room. This is a revelation with which too few physicians are familiar, and the interest shown by those who saw the initial showing of the film indicates that it will be welcomed in medical circles.

The film is a 16-mm. sound movie and will be available to County Medical Societies in New Jersey this fall, upon request to Mr. Roland F. Simons, care of Johnson and Johnson, New Brunswick, New Jersey. Time required is 34 minutes and the film, operator, projector and screen are furnished without cost. It can be shown wherever there is the ordinary 110-volt circuit A. C. and County Society program committees may schedule this film when they are making up their programs for the coming year.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held at the Traymore Hotel on April 10. DR. HARRY SUBIN, President, presided. DR. EDWARD A. SCHUMANN, well-known teacher, obstetrician and gynecologist of Philadelphia, was the guest speaker. His subject was "The Various Types of Caesarian Sections and Their Indications". Methods were compared and slides shown to illustrate different techniques used. Discussion was provided by DRs. CARRINGTON, BROWN and ALLMAN.

The minutes of the last regular meeting were read and approved.

The endorsement of this Society for the building of a government hospital on property donated by the Board of Freeholders was conveyed to President Roosevelt, Senator Knox and Senator Smathers.

Atlantic County presented a resolution endorsing Annual Registration to the House of Delegates of the State Medical Society.

The Society unanimously indorsed the reelection of Dr. Hilton S. Read as a Delegate of the State Society to the American Medical Association, and Dr. Carrington told of the plans of the coming meeting of the American Medical Association and the difficulties which had to be overcome because of rumors of danger here from enemy craft.

Resolutions on the death of Dr. Samuel Stern were adopted.

The President appointed as a Nominating Committee for the coming election of officers: Drs. Davidson, White, Carrington, Crane and Guion.

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The last scientific meeting of the *Burlington County Medical Society* before the summer recess was held in Moorestown on April 9, 1942.

DR. DEAN LEFAVOR welcomed to the meeting DR. PAUL MEGRAY, JR., of Camden County; DRs. DIVERTY and WOOD from Gloucester County; and CAPTAIN I. L. FISHBEIN of Woodbury, N. J., who is in the Army Medical Corps.

DR. JAMES S. SHIPMAN of Camden spoke on the subject "Ocular Injuries and Their Treatment". He stated that the general practitioner should know more about the eye than he has learned in his medical school, and discussed methods for removal of small foreign bodies; for chemical burns; for injuries by hot metal; and for the complications which might arise from any of these. Dr. Shipman also described in detail the correct method for repairing a vertical laceration of the eyelid, and stated that many unnecessary plastic operations can be avoided if this procedure is followed.

The discussion was led by DR. DEAN LEFAVOR and many other members presented their own problems.

May 1, 1942, is Child Health Day. It is hoped that

as many children as possible will this year be vaccinated against smallpox and inoculated against diphtheria.

DR. NORMAN SCOTT announced that the Board of Governors of the Medical Service Administration had advised a voluntary plan similar to Plan II be operated. The original Plan II was not intended for indigent persons. The County Society approved the change.

To the next meeting in May, the wives of the members are invited. The time and place and entertainment will be announced later.

### CAMDEN COUNTY

Thomas H. McGlade, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held at the West Jersey Homeopathic Hospital on April 7, 1942, at 9 p. m., with DR. D. F. BENTLEY presiding.

DR. WESLEY JACK spoke on the progress being made by the tumor clinics and urged that private as well as ward cases be registered in these clinics.

The scientific program consisted of five case reports by members of the West Jersey Hospital Staff and were as follows:

Pruritus Ani, DR. W. J. BURKETT.

Diaphragmatic Hernia, DRs. WESLEY JACK, RALPH A. WARWICK and E. C. SHULL.

Hydatidiform Mole, DR. SAMUEL GOLDMAN.

Congenital Anomaly of Kidney and Ureter, DR. RALPH S. WRIGHT.

Meningococcal Meningitis (two cases), DR. H. B. MARK.

They were all extremely interesting and instructive.

The memoirs of the following two physicians, both former members of the Society, were presented:

DR. W. K. BROWNING of Merchantville, N. J., died January 22, 1942. Dr. Browning was Vice-President of the Pennsylvania Academy of Physical Medicine and Secretary-Treasurer of The Physicians' Motor Club of Camden, N. J.

DR. HARRY JARRETT of Camden, N. J., died January 29, 1942. Dr. Jarrett received the Fifty-Year Certificate for Meritorious Practice in 1939.

At the close of the meeting a collation was served. There were eighty-one members present.

### CUMBERLAND COUNTY

E. C. Lyon, M.D., Reporter

The annual meeting of the *Cumberland County Medical Society* was held on April 14 at the House of Friendship, Millville. DR. W. SHERMAN GARRISON conducted the meeting. Most of the members were present.

After the balance in the Society's treasury had been determined, it was decided to buy four \$100 war savings bonds.



DR. M. F. SEWALL reported on the emergency medical preparations in the county.

The new officers elected were: President, DR. E. J. THALHEIMER; Vice-President, DR. MURIEL RAMSEY; Secretary, DR. MARY BACON; Treasurer, DR. HERBERT H. WILSON; Reporter, DR. E. C. GREEN; Censor for three years, DR. CHARLES GRAY. The Executive Committee members elected were: DRs. REEVES, MILLER and WOODRUFF. DR. ALBERT B. KUMP was elected Delegate to the State Society meeting, with DR. E. C. LYON as Alternate. DR. H. B. WALKER of Vineland was elected Nominating Committee Delegate to the annual state meeting.

DR. NEWBERRY, from the Federal Department of Agriculture, outlined the plan for care of migratory labor. Drs. Reeves, Sewall and Bacon were appointed a committee of three to work out the medical plan for a camp near Bridgeton.

The scientific discussion, "Shock Treatment in Mental Disease", was presented by DR. GEORGE WILSON, Neurologist at the Philadelphia General Hospital. "Mental illness has been classified into organic, toxic and functional groups," said the speaker. "At the present time the functional group of cases comprises by far the largest number of mental cases that are seen, both in and outside of the mental hospital. A year or so after the discovery of insulin, it was used as an appetite producing agent, and from that time up until about 1930 there have been occasional reports of its beneficial effect. In 1930 Dr. Sakel of Vienna began to use insulin in treating drug addiction cases, and a little later tried it in dementia praecox, i.e., by giving large shock doses. In 1933 he made his first report on this procedure.

"The technique of insulin shock treatment varies in different clinics but in general it consists of giving the patient *without food* a dose of insulin early in the morning, 7 o'clock, six days a week, with the seventh day as a rest period. This allows him to go into shock and subsequent coma until 11 or 12 o'clock.

"The newest form of shock treatment and the one that is being used most frequently at the present time is the *electrically* induced convulsion. Electricity has a number of advantages over other forms, in the short time required to give it, the lack of any premonitory sinking feelings, the control of the dosage and the relative absence of complications.

"A special apparatus used for producing the shock is so designed that two electrodes are placed on the forehead and the patient is usually given approximately 400 to 500 milliamperes of current for three-tenths to one-tenth of a second. The voltage is usually about 80. The only immediate requisites are that the patient shall have no food in the stomach and that he shall have taken no drug with marked anticonvulsive properties in the 24-hour period preceding the treatment.

"Recent figures for electric shock therapy give a recovery rate in involutional melancholy as high as 85 per cent. In manic depressive psychoses both phases, 70 per cent, schizophrenia, no recovery, and in psychoneuroses, 60 per cent."

## ESSEX COUNTY

P. H. HOSP, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held on Thursday, March 12, 1942, at the Academy of Medicine. PRESIDENT FRANCIS C. WEBER called the meeting to order at 9:15 p.m.

Dr. Weber used a novel idea in introducing the speaker of the evening. He gave more than twenty of the past and present positions and titles held by the speaker and then asked the audience, "Now who do I mean?" The audience immediately recognized CLARENCE O'CROWLEY.

Dr. O'Crowley, Assistant Professor of Urology, University of Pennsylvania, accepted the compliment graciously and in turn introduced DR. OSWALD S. LOWSLEY, President of the American Urological Society, who spoke on "Some Recent Advances in Modern Urology".

The speaker, in his pleasing way, told us that urology is the oldest and still one of the newest of the specialties in the medical world. The earliest operation was that of cutting a stone out of the bladder. Urology is a narrow specialty on account of the few organs treated but also one of the widest, since these organs have so much to do with various diseases. He spoke of tumors and stones in urology and the importance of making rectal examinations. He said you must make the correct diagnosis in order to be able to give the proper treatment. He mentioned the sulfa drugs and spoke of their value in urology.

The meeting was featured by a clear and instructive motion picture of "Total Perineal Prostatectomy" performed by Dr. Lowsley.

The audience was large and very appreciative.

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The regular meeting of the *Essex County Medical Society* was held at the Academy of Medicine on April 9th, 1942. DR. FRANCIS C. WEBER presided.

The minutes of the last Council meeting were read and the meeting was turned over to the scientific program.

DR. WILLIAM D. STROUD, Professor of Cardiology, University of Pennsylvania Graduate School of Medicine and School of Medicine, Philadelphia, climaxed a week of intensive study and lectures on the "Heart". His topic was "Modern Therapeutics in Cardiology".

Dr. Stroud is a pleasing speaker and made his talk practical. It is the manner in which we tell our patients they have cardio-vascular diseases that is important. We can throw fear into them, which tends to make them worse, or we can make them philosophical about their condition. We must aid them to realize that they must follow an easier daily routine. Do not advise not to do this and do not do that, but make them as comfortable as possible and give them less to worry about. Let them learn how to live with a coronary disease. Teach them how to live normal useful lives. As to rheumatism, Dr. Stroud suggested that after the acute stage we should try to keep them in a convalescent home or hospital. Later endeavor to get rid of the causative factors (tonsils, etc.). On the screen were

shown some beautiful illustrations. Drs. HARVEY M. EWING and AARON PARSONETT discussed the paper. The auditorium was filled.

April 6th to 10th was designated as Heart Week. The Heart Committee put on a very extensive program. There were many talks on heart disease given to lay groups during this time. They were all well received.

A program was presented at the Martland Amphitheatre in the City Hospital on April 8th at 4 p.m., and the following speakers took part: DR. FREDERICK A. ALLING, Chairman of the Heart Committee; DR. H. C. CROSSFIELD, who spoke on the Treatment of Coronary Disease; DR. H. H. GOLDBERG spoke on Congestive Failure; DR. J. G. KAUFMAN spoke on Rheumatic Disease. DR. F. P. WILLEY's topic was Hypertensive Heart Disease. Dr. Harrison Martland spoke and showed pathologic specimens of the heart with the aid of the new Kodachrome. The meeting was a huge success. Many thanks are due those who made it so.

In reading the message of the President, Dr. Weber, one is amazed at the statistics showing the prevalence of heart disease in this country. It is estimated that there are about 4,000,000 persons in the U.S.A. with some form of heart disease, or about three per cent of the population. During the First World War, 26 draftees per 1,000 were rejected for this cause. In the present emergency of 19,923 registrants examined by the Selective Service Local Boards 2,000, or 100 per thousand, were rejected for disease or defects of the cardio-vascular system.

The following were elected to membership: DR. SAMUEL B. GREENWOOD, Newark; DR. THOMAS F. G. McAVENEY, East Orange, and DR. THEODORE R. MILLER, Montclair. Associate, DR. ISRAEL RAVITZ, Bloomfield.

## GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of the *Gloucester County Medical Society* was made most interesting by the timely talk of DR. EDWARD WEISS, Clinical Professor of medicine at Temple University, whose subject was "The Recent Advances in the Cause and Treatment of Hypertension". He stated that in the United States every other individual after the age of fifty dies of cardio-renal disease. Of these, one-half have had hypertension. Hypertension is supposed to be due in part to our advanced civilization and is unknown in the Negro and Chinese races. It is known to be a constitutional and familial disease. The vegetative, nervous and endocrine systems provide important causative factors. The emotional status is quite frequently involved, especially where fatigue and long periods of emotional stress are present. In the treatment, milk, eggs and red meat are allowed freely. The diet plays very little part in the treatment at the present time. The medical treatment now consists of:

1. Restricting the manner of living.
2. The use of nerve sedatives.
3. Provision of proper rest.

4. The use of sulfocyanates. These are usually quite toxic but can be controlled if the blood level is kept between 8 to 12 mgs. The blood pressure is reduced in 50 per cent of the cases provided a careful control is kept.

5. Sympathectomy. The surgical removal of a section of the splanchnic nerve is beneficial in some cases.

DR. WILLIAM PEDRICK reported that the number of doctors in Westville subject to draft call is at least three out of four. He suggested that some effort be made to keep sufficient doctors at home to care for the civilian population.

DR. JOSEPH HUGHES reported that the Medical and Surgical Plan of New Jersey was approved by the State Society and entitled its members to receive medical and surgical service as provided. The hospital bill for maternity cases is also paid. This plan goes into effect when 51 per cent of the doctors in the county have given their consent.

## HUDSON COUNTY

John N. Connell, M.D., Reporter

The *Hudson County Medical Society* met March 3, 1942, at the Masonic Club, Jersey City, N. J., with the President, DR. ANTHONY J. CONTY, presiding.

### REPORT OF EXECUTIVE COMMITTEE

DR. A. J. CONTY: "At the last meeting of the Executive Committee the subject of Annual Registration was taken up and a letter from President Lewis was read, asking consideration by the Society of this subject."

This communication was discussed in detail and the Executive Committee recommended to the Society that they announce their opposition to the principles of Annual Registration of Physicians.

DR. B. T. D. SCHWARZ stated that inasmuch as the State Board of Medical Examiners is an agency of the State Government and doing a public service, he did not see the reason at this time for the arguments presented for the continuance of the Board's activity.

The recommendation of the Executive Committee was adopted.

### STATE DEPARTMENT OF HEALTH

A communication was received from the State Department of Health pertaining to Negro health and urging support by the Society of the program to provide free chest x-rays in Jersey City some time in May among the colored population.

The co-sponsors of this demonstration are the State Department of Health, Hudson County Sanatorium, Hudson County Tuberculosis League, and the Jersey City Board of Health. Dr. Pollak and his staff will interpret the Powers' Company paper films.

The following figures establish the need for this work:

Deaths in Hudson County 1940—from tuberculosis: White, 288; colored, 44.

Colored deaths are 13.6 per cent of total, but population content is only 2.4 per cent.

Cases reported per death are low for the colored: White, 2.2; colored, 0.5. (Standard is two per death.)

#### MEDICAL-DENTAL SERVICE BUREAU

A communication was received from the Medical-Dental Service Bureau of Passaic and Bergen Counties, Inc., stating that the Board of Trustees of this Bureau has adopted a resolution calling for the amendment of the Certificate of Incorporation of the Bureau, extending the services of the Bureau to physicians and dentists having offices in counties other than Passaic and Bergen.

In order to convey this information to the Hudson County Medical Society, they requested space in the next issue of the Bulletin, and this request was granted by the Society.

#### REPORT OF NOMINATING COMMITTEE

DR. J. L. EVANS read the following nominations:

President, W. A. Pinkerton  
Vice-President, T. McG. Brennock  
Treasurer, A. J. Conty  
Secretary, V. P. Butler  
Reporter, H. Gorenberg

Board of Trustees, three years to 1945: W. J. Gleeson; one year to 1943: H. Spence (to fill unexpired term of J. F. Norton)

Board of Censors, three years to 1945: R. L. Ballinger

Audit Committee, three years to 1945: H. B. Ainsley  
Publication Committee, three years to 1945: P. Kresch, N. M. Alter, J. D. Pellarin, N. Meyerson; one year to 1943: J. J. O'Shea (to fill unexpired term of W. T. Callery, deceased)

Delegate to State Nominating Committee, to serve in 1943: J. F. Norton

Alternate to State Nominating Committee, to serve in 1943: J. L. Evans

Committee on Constitution and By-Laws, three years to 1945: A. C. Ruoff

Legislative Committee, three years to 1945: M. Shapiro, G. Ginsberg, W. Weber

Election Committee, to serve in 1943: S. G. Scott, L. A. Schneider, D. D. Dougherty, W. M. Doody, J. J. Danielson, M. Shapiro, S. S. Schept

Maternal Welfare Committee, three years to 1945: J. F. Norton, S. A. Cosgrove, W. A. Pinkerton

Delegates to State Convention, three years to 1945: E. J. Chapman, T. J. Schuck, B. S. Pollak, S. A. Cosgrove, J. L. Evans, R. L. Ballinger, C. J. Larkey, J. J. Quinn, G. Ginsberg, W. W. Maver, A. C. Ruoff; two years to 1944: N. M. Alter, (to fill unexpired term of W. T. Callery, deceased)

Alternates to State Convention, three years to 1945: E. E. Lupin, J. Madaras, J. J. O'Connor, H. Fialk, A. Schlein, J. P. Donnelly, S. Kooperstein, W. J. Snyder, P. J. Bonanno, H. A. Granelli, J. N. Connell

DR. W. A. PINKERTON, Chairman of the Dinner Committee of the Hudson County Medical Society, reported a profit of \$31.20 from the Annual Dinner held on February 14th at the Masonic Club.

The following were elected to membership: DRs. MARIO G. DEL BAGLIO of Secaucus, VINCENT G. FAY

of Harrison, GERALD W. SINNOTT, HERMAN PRESTON PRICE and F. STANLEY STANKIEWICZ of Jersey City.

DR. MEREDITH F. CAMPBELL, Professor of Urology, New York University College of Medicine, gave a most enlightening presentation of the subject "Common Urologic Conditions in the Young".

The discussers were DRs. BUTLER, WOODRUFF, DALY, O'CONNOR, MARKOWITZ, CONNELL, MEYERSON and KATZ.

DR. LEROY A. WILKES, Executive Officer and Acting Editor of the State Journal, spoke on the subject "The Itch to Write", and gave helpful suggestions on writing articles for the *Journal*. Dr. Wilkes stated that the paper was prepared by the Editor, Dr. Davidson, who was called into service with the Army, and these suggestions will appear in the *Journal* at an early date.

#### MIDDLESEX COUNTY

Cyril S. Hutner, M.D., Reporter

The March meeting of the *Middlesex County Medical Society* was held on the 16th at Roosevelt Hospital, Metuchen, N. J. DR. M. F. URBANSKI, President, called the meeting to order.

DR. BERNARD M. KRAMER of Perth Amboy was elected to Associate Membership.

Dr. William E. Sherman reported on the Advanced Course in First Aid for M.D.'s only, to be given at the Middlesex General Hospital, New Brunswick, April 6th to 10th, inclusive, from 9:00 p.m. to 12:00 midnight.

Dr. Edward F. Klein reported that the advanced first aid course in Perth Amboy was unsuccessful and unsatisfactory.

Dr. Cyril I. Hutner reported on the arrangements for the June outing with the dentists.

Place—Jumping Brook Country Club, Neptune (Asbury Park).

Date—Wednesday, June 17, 1942.

Price—\$2.50 per member—Green's fee \$1.00 extra.

In the scientific session DR. JEFFREY M. ROBERTSON, Surgeon Lieutenant Commander, R.N.V.R., British Naval Liaison Office, Brooklyn, spoke on "A Naval Surgeon's Wartime Experiences in the Mediterranean".

The American Hospital Supply Corporation showed a film on "Blood Preparation". Subjects covered in the picture included the parenteral solutions produced by Baxter, and their method of use; the equipment for indirect blood transfusion, showing the actual taking and dispensing of blood; and the taking of blood, centrifugation to obtain the plasma, by aspiration, and finally the dispensing of plasma.

A representative of the corporation displayed for the benefit of the members in attendance and answered their questions.

#### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

"Sciatica" was the subject for the sixth and final lecture of the Post-Graduate Education Course, held at Greystone Park, on April 16, 1942, a large number of physicians enjoying the speaker, DR. ALAN



DEFOREST SMITH, Clinical Professor of Orthopedic Surgery, College of Physicians and Surgeons, Columbia University, New York City. PRESIDENT TELLER introduced Dr. Smith.

Dr. Young gave the report of the Executive Committee which recommended the election of Dr. THEODORE GEBERTIG, contingent upon certification of his A. M. A. credentials.

It was decided to take no action on Assembly Bill 170, which concerns sterilization of the feeble-minded but to await the action of the House of Delegates at the coming State Society meeting.

A Nominating Committee consisting of Drs. CABBERRY, TESKEY and GEARY was appointed.

The recommendations outlined by Dr. Scott concerning the Medical-Surgical Plan were ratified.

Dr. Pinckney, Chairman of the Physician's Welfare Committee, gave the Committee's preliminary report and suggested that any member going into the Military Service familiarize himself with the Civil Relief Act of January 26, 1940, as applied to the Medical Profession; also that cards be printed and placed in every member's office to the effect that patients changing doctors because their regular attending M.D. has gone into Military Service be earnestly requested to return to their own doctor on his return to civil practice following his discharge from Military Service. It is also requested that patients inform the substituting doctor, for his records, who has been their regular attending physician. It was not considered feasible to arrange any fee percentage deduction scheme, but such arrangements might be made between individuals.

It was moved that this report be placed on file to await possible action at the State Society meeting.

Our speaker in his remarks pointed out that sciatica is the name of a symptom and is not a clinical entity, and that there are many causes of this symptom, and in order to make a diagnosis of the cause, careful orthopedic and neurological examinations should be made, as well as x-rays of the lumbo-sacral region. The cause is often mechanical. There are those which cause pressure within the spinal canal, such as herniation of the nucleus pulposus which may occur after injury and is usually located posteriorly or laterally where the disc is thinnest, most commonly in the lumbo-sacral region. Pain may involve only the leg or ankle, or the whole thigh, and there may be a limitation of motion of the back due to muscle spasm. The patient may limp. In cases of long duration there may be muscle atrophy and diminution of sensation, and diminished or absent ankle jerk on the involved side.

A lumbar puncture is considered important. The spinal fluid often shows an increase of protein, any amount above 40 mg. per 100 c.c. being suggestive of disc pathology.

After the diagnosis is made, the treatment is surgical removal of the disc using the new technique which avoids laminectomy.

Spinal cord tumor must be ruled out in sciatica, also the scars of old inflammatory processes, of the

dura or arachnoid such as might follow old lumbo-sacral strains.

Irritation of the nerve root in the foramen as it emerges from the spine may be due to a displacement of a vertebra, producing sciatica; posterior displacement of the fifth lumbar being common, as are anatomical variations between the two sides of a vertebra in the lumbo-sacral area.

Osteo-arthritis of the lumbar spine with the nerve roots caught in the exostoses, and tuberculosis in this area may cause sciatic symptoms. Muscle pressure on the sciatic nerve and contracture of the fascia lata are also possible causes of the symptom.

Dr. Smith pointed out that conservative measures, such as bed rest, extension, heat and massage often produce relief, but that a certain number of cases may require more radical treatment.

In the discussion which followed it was brought out that symptoms may be intermittent, and that the herniated disc itself may spontaneously be reduced.

## OCEAN COUNTY

L. W. Falkenburg, M.D., Reporter

The monthly meeting of the *Ocean County Medical Society* was held on April 8, 1942, at the Lakewood Hospital. After the reading of the minutes and communications, nomination of officers for the coming year was made.

The scientific portion of the meeting consisted of the presentation of a case by Dr. L. W. FALKENBURG, Pathologist to the Lakewood Hospital, illustrating portal cirrhosis of the liver with subacute bacterial endocarditis.

## PASSAIC COUNTY

I. Okin, M.D., Reporter

The joint meeting of the *Passaic County Medical and Dental Societies* was held at the Paterson Board of Health Building on April 9, 1942, at 9:00 p. m. Dr. SIGURD W. JOHNSEN, President, presided.

Active Members elected were Drs. EDWIN J. ALLEN and EDWARD S. BALLE of Paterson, Dr. SAMUEL T. BERNSON of Pompton Lakes and Drs. JOSEPH GUARRAIA and EUGENE V. ROBERTSON of Hawthorne. Associate Member: Dr. RICHARD LANG of Passaic.

DOUGLASS B. PARKER, M.D., D.D.S., Assistant Professor of Oral Surgery at Columbia University, discussed "The Management of Traumatic Injuries to the Face and Jaws".

He reviewed the various types of splints used, especially those employed in comminuted fractures of the jaws. His talk was illustrated with lantern slides. He stressed the fact that during the present war, injuries to the jaws and face were usually so severe that patients died before they could be treated.

A large group was present.

## SALEM COUNTY

Lee C. Hummel, M.D., Reporter

The April meeting of the *Salem County Medical Society* was held at the Dupont Country Club, Carnegy's Point, New Jersey.

Dr. E. E. EVANS presided over a well-attended and enthusiastic meeting.

A letter from the "Old Age Assistance" Board was read reviewing the matter of physicians' charges, and after some discussion the proposal was accepted as offered.

Drs. Suter and Savage were appointed as representatives from our Society to take the course in gas warfare for physicians. These men are to instruct the other members of the Society on completion of their course.

Our next meeting on May 8 is the annual shad dinner.

The Delegates to the State Society were instructed to vote for medical registration with a maximum limit of three dollars for the registration fee.

This year the attendance and interest in the Society has been very gratifying. Our average attendance varies from twenty-two to twenty-five out of a possible thirty. The programs have been especially good which, I believe, accounts for the interest and support by the members. Thanks are extended to the officers and committee.

Officers elected for the coming year follow: President, F. L. PERRY; Secretary-Treasurer, J. S. DUNN; Vice-President, L. C. HUMMEL; Reporter, H. F. SUTER. Nominating Committee: C. L. FLEMMING. The delegates to the county societies remain unchanged.

The scientific meeting was given over to Dr. REUBEN SHARP of Camden, New Jersey, who spoke on "Peptic Ulcer". He gave a comprehensive survey of the subject touching on the different theories of etiology and the newer methods of treatment. A spirited discussion followed, which was entered into by most of the members present.

Dinner was served at the club following the meeting.

## SOMERSET COUNTY

D. O. Hamblin, M.D., Secretary

A regular meeting of the *Somerset County Medical Society* was called to order by the President in the Nurses' Home of Somerset Hospital at 8:30 p.m. on March 12, 1942.

Two speakers were introduced to the Society by the President. The first speaker was Dr. JOSEPH F. LONDRIGAN, Second Vice-President of The Medical Society of New Jersey, who brought us greetings from the President of the State Society, Dr. T. K. Lewis. He reviewed briefly the present activities of the State Society, and dealt most specifically with the attitude of the Somerset County Society with regard to the Medical Service Administration Plan. He expressed the opinion that the attitude of our Society, as reflected in the expression that "socialized medicine is at present in abeyance", was probably not well conceived. He felt that the State

Society was properly planning, through the Medical Administration Plan, to take steps to relieve certain unsatisfactory phases of medical services to the low income group, and urged strongly that we reconsider our stand. He particularly emphasized the fact that our Society was the only county society in the State which had not approved the Plan and that if for no reason other than the unanimity within the State Society, this would be highly desirable. A motion was made that the matter be tabled. This motion was regularly carried.

Dr. Fritts then introduced Dr. A. W. BINGHAM who gave us an excellent paper on the subject "Keeping the Normal Obstetrical Case Normal". He counselled conservatism in the handling of all cases, and emphasized the need for thorough prenatal care, and prompt action when deviations from normal are noted during this period. He also laid great stress on refraining from interference during the course of labor, unless it is absolutely indicated. He commented at some length on the maternal and fetal statistics for Somerset County in comparison with other counties in the State, and pointed out that last year Somerset County had greatly improved its record. The appreciation of the Society for his talk was manifested by a rising vote of thanks.

## UNION COUNTY

Edward G. Bourns, M.D., Reporter

The *Union County Medical Society's* Annual Meeting was held in Muhlenberg Hospital, Plainfield, April 8th, 1942, at 9 p.m. Dr. LORRIMER B. ARMSTRONG presided.

The minutes of the March 11th, 1942, meeting were read. Reports on special meetings and resolutions on the death of Dr. A. J. Drury were read.

## COMMUNICATIONS

1. A letter from Dr. L. V. LOPEZ, Chief Medical Officer, Veterans Hospital, Lyons, offered opportunities for physicians in the Veterans Administration field.

2. A letter from Dr. WILKES brings to attention May 1st as the official Child Health Day by Presidential proclamation and emphasizing "Immunization and Vaccination as the Aim for 1942".

3. A letter from Dr. WILKES in regard to the problem of medical facilities available in the Winfield Park government project.

4. Request from Dr. DENGLE for an audience with the proper County Society committee to consider the recommendation of a *County Isolation Hospital and Hospital for Incurables*.

## COMMITTEE REPORTS

1. Industrial Hygiene Committee: Dr. CARLISLE, Chairman, reported active work carried out under the State Committee for 1941 (detailed report in April, 1942, State Journal). Report accepted.

2. Executive Committee: Minutes of April 6th, 1942, meeting read and accepted.

3. Treasurer's Report: Dr. BANKER reported 1941

expenditures, and read in detail the 1942 budget. Letter from auditor states that cash receipts and disbursements correctly presents the operation of the County Medical Society for the year under review. It was voted that the Treasurer's report and budget be accepted.

DR. M. J. SCALESSA of Summit was elected to membership.

The Union County Medical Society recommend to The Medical Society of New Jersey that the State Society have representation at the meeting of the American Medical Association Congress on Industrial Health in Chicago, January 11, 1943.

It was voted that the county assessment for 1942-43 be \$9.00.

It was voted to approve the recommendation of the Executive Committee to purchase three (\$740) Defense Bonds.

Recommendation for approval of Medical-Surgical Plan. DR. SCOTT discussed Plan No. 2, Medical Service Administration Plan, under this new name. The Medical Service Administration Plans for indigents and farm residents are to continue but industry wished no confusion with income from an indigent plan for health insurance and therefore the separate Medical-Surgical Plan was evolved.

MR. SORG, President of the Hospital Service Plan of New Jersey, explained in detail his company's co-partnership with the Medical-Surgical Plan. This plan was discussed from the floor by many physicians. It was voted that every member of the County Society be notified that a special meeting is to be held in Elizabeth within the next week when voluntary health insurance will be discussed in full and a vote taken for approval for Union County's participation in the Medical-Surgical Plan.

DR. SCOTT outlined the Procurement and Assignment Service, indicating its position under the Office of Defense, Health and Welfare.

#### ELECTION OF OFFICERS

DR. ARMSTRONG recognized a quorum as existing, and DR. E. P. WEIGEL, as Chairman, read the ballot of the Nominating Committee. It was accepted unanimously and the Secretary cast the ballot. Those elected were:

President, GEORGE E. SEYMOUR  
First Vice-President, ELTON W. LANCE  
Second Vice-President, IRVING LERMAN  
Secretary, FREDERIC W. LATHROP  
Treasurer, GEORGE T. BANKER  
Reporter, EDWARD G. BOURNS

Trustee: E. P. WEIGEL—1945

Board of Censors: M. A. SHANGLE—1947

Public Health Committee: WILLIAM M. GOLDEN—1947

Public Relations Committee: NORMAN W. BURRITT—1947

Legislative Committee: LINDLEY LEGGETT—1947

Finance Committee: WILLIAM E. BOOZAN—1945

Scientific and Literary Committee: J. M. CARLISLE, J. J. LABOW and D. SPIVACK

Medical Service Bureau Committee: THOMAS J. WALSH—1945, J. J. BUTENAS—1945

Delegate to State Meeting (term expires 1943):

State Nominating Committee, WATSON B. MORRIS  
Alternate, NORMAN W. BURRITT

Delegates (term expires 1945): E. P. WEIGEL, H. V. HUBBARD, C. H. SCHLICHTER, W. E. BOOZAN, I. GELBER, GEORGE KNAUER, JACOB REINER.

Alternates: L. H. LEGGETT, R. C. PETERS, STANTON H. DAVIS, R. J. HOLLAND, A. R. CASILLI, J. D. TIDBECK, FRANK WILLIAMS.

DR. ARMSTRONG, in his interesting presidential report, mentioned certain highlights which brought vividly to his county society membership the activities of the current year in a way that might be advantageous for emulation by county society presidents generally. These activities can only be included in abstract in *The Journal*. DR. ARMSTRONG emphasized the accelerated pace at which current events are now moving, and that as a result of this increased rate the contributions to war and peace made by our profession must now and in the future be speeded up.

Our county, as host at the Fourth Clinical Conference, made a valuable contribution in the form of an opportunity to see first-hand modern industrial medical practice by visitation to plants. DR. MACKINTOSH, of the British War organization, serving in this country, brought to our Society an account of the experience of medical men in war work in England, and Johannes Steel, radio commentator, gave us a bird's-eye view of war problems which led to and which will grow out of the war and require solution. The importance of nutrition among the problems faced by all of us must be emphasized, and the fine work of the County Society's headquarters staff is applauded.

DR. ARMSTRONG urged continued integration of effort of the member physicians with those of the Professional Guild, the Nurses, the Welfare Workers and the Welfare Board of Union County, the Medical Service Bureau and those in charge of the Cancer Control program.

DR. ARMSTRONG further laid emphasis on the need for the closest coöperation in support of DR. SCHLICHTER's efforts in the war preparations and finally urged the medical men of Union County to be thinking of the problem of medical service distribution in the future which they must face not only as a war emergency but in the post-war period.

DR. SEYMOUR accepted the chair from DR. ARMSTRONG and announced that, if possible, the special meeting would be held Wednesday night at Elizabeth General Hospital.

#### SPECIAL MEETING FOR MEDICAL-SURGICAL PLAN OF NEW JERSEY, ELIZABETH GENERAL HOSPITAL, ELIZABETH, APRIL 14

DR. SEYMOUR, President, introduced DR. REINER of Elizabeth, who gave a comprehensive report of the Medical-Surgical Plan of New Jersey (which is Plan No. 2 of the Medical Service Administration of New Jersey under a separate name).

DR. E. W. SPRAGUE, Newark, outlined step by step the development of this plan, and answered many questions concerning its present status and urged



its adoption. He invited all members to attend the Academy of Medicine meeting April 16th. "Trends in Community Practice" by WILLIAM H. PERKINS, M.D., Dean of Jefferson Medical College.

DR. LEWIS, President of the State Medical Society, spoke briefly on the need for coöperation between the medical profession and industry and asked that Union County show its support of the committee by approving this plan.

After considerable discussion from the floor the Union County Medical Society defeated the Medical-Surgical Plan of New Jersey.

### SUMMIT MEDICAL SOCIETY

E. H. Macpherson, Secretary

The March meeting of the *Summit Medical Society* was held at Fair Oaks Sanitorium as the guests of Dr. Prout, one of our Charter Members, whose 50 years in medical practice was celebrated by the Society last October.

The President, DR. STEUART, presided. Thirty-one members and nine guests were present. Dr. Prout welcomed the members.

DR. ERNST A. MAY, the Attending Roentgenologist at Overlook Hospital, was unanimously elected to membership in the Society.

Dr. Steuart mentioned the problem of Red Cross training courses that may be offered to physicians locally. This aroused much discussion. DR. DE VRIES volunteered to provide a Red Cross course for those members desiring it. It was decided to hold a meeting at Overlook Hospital on April 12th, after the air raid practice. DR. MORRIS will discuss war gases at a special meeting in the near future.

DR. ERNST A. MAY described the x-ray slides revealing malignant and non-malignant lesions of the gastro-intestinal tract. He stated that all gastric lesions in the greater curvature in patients over 50 years of age should be regarded as being malignant until proven otherwise. Dr. May believed that any suspicious case should be explored surgically, as in this manner early carcinomatous lesions may be discovered and often cured. Operation should be considered when an ulcer is of short duration in a patient over 50 years of age; when the ulcer is larger than 2.5 cm. in diameter; when located on greater curvature in the pre-pyloric region; and when no free Hcl is present.

Following the meeting a collation was served in the dining room.

The regular monthly meeting of the *Summit Medical Society* was held at the Canfield Tea Room on Tuesday evening, April 28th, at 9 p.m.

PRESIDENT STEUART presided, and 26 members and nine guests were present.

DR. WATSON B. MORRIS will give an illustrated lecture on "War Gases, Burns, and Blast Concussions with Treatment" at a special meeting at the Canfield Tea Room on Tuesday evening, May 12th, at 9 p.m.

Dr. Steuart expressed his appreciation on behalf of the Summit Medical Society to DR. DE VRIES for his Red Cross instruction rendered to the members.

DR. GERALD H. PRATT of New York Post-Graduate Hospital gave an excellent presentation of "Surgical Treatment of Varicose Veins, Ulcers and Thrombosis", which was illustrated by colored motion pictures shown today for the first time at the New York State Medical Society. A general discussion followed.

### NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

Cedric C. Carpenter, M.D., Secretary

The last regular meeting of the *Northern New Jersey Dermatological Society* for the 1941-42 season was held on March 18th at the Academy of Medicine, Newark, N. J. DR. JOHN KILEY, the Vice-President, conducted the meeting.

After the presentation and inspection of cases the following topic was taken up for discussion: "Uses and Reactions of the Sulfa Drugs in Dermatology".

A free discussion of the problem pertaining to the use of the sulfa drugs brought out some very interesting personal experiences with the use of chemotherapy in some unusual and common types of skin diseases. The membership seemed to favor the use of the drugs in ointment form, although some recent work tends to show that, in topical application, the drug might not be liberated from the ointment base, as it would in powder or solution form. Particularly striking results have been obtained in chaneroid and lymphogranuloma with the use of sulfathiazole. Dermatitis herpetiformis seems to be helped best by sulfapyridine. The use of sulfa drugs was found inconstant in the common pustular bacteriides of the hands and feet, in cystic acne, and furunculosis. Many of the members reported very good results with an ointment containing sulfanilamide or sulfathiazole in the treatment of impetigo. A pyogenic granuloma, apparently cured by local applications of sulfanilamide ointment, was also reported and a case of long-standing lupus vulgaris which had not been cured by the gold compounds or salt free diet, has disappeared after the use of forty grains of sulfanilamide by mouth daily, for a three months' period.

Stress was laid on the great variety of skin reactions as toxic manifestations to the use of these drugs. Many are limited to the exposed parts, such as the face and hands, due to the photosensitization effect. The lesions were varied from a mild morbilliform or papular type dermatitis to complete exfoliation of the skin. One case of lichen planus-like lesions scattered all over the body, but not on the mucus membranes, had been seen following the excessive intake of sulfathiazole.

The following officers were elected for the coming year: President, DR. JOHN KILEY, Newark; Vice-President, DR. C. C. CARPENTER, Summit; Secretary, DR. HENRI ABEL, Elizabeth; Treasurer, DR. IRVING LEHMAN, Newark.

On Dr. Charles Mitchell's motion, it was voted that twenty-five dollars be sent by the Treasurer to the Academy of Medicine, Newark, N. J., as a token of appreciation for the use of their rooms for meetings.

## WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Chairman Press and Publicity

### DOWN WITH THE COUNTY LINES

Each month, in fifteen counties, there are fifteen meetings of County Auxiliaries. What goes on? No Auxiliary member in the next county would have a way of knowing. The county lines are as an impenetrable barrier. The "South" county has a pet project that has worked out nicely and proven to be of value as a public relations scheme. The "West" county would welcome just such a suggestion. In fact, the members of the "West" county are not

turning out at meetings, reason—"we do not do anything constructive".

Is this not a deplorable situation? The cure is to promote intercounty visiting to bring about an exchange of ideas and promote the friendship between physicians' families, which is one of our primary reasons for an organization. Now, more than ever before, we need to present a solid front with singleness of purpose.

Let us push down the county line barriers and work as one unit. Be neighborly!

**"O"** Is for Ocean County - **"P"** Is for Passaic County  
**"W"** Is for Warren County

These articles, written by the Presidents of the County Auxiliaries, are published each month and describe the procedures, aims and pet projects of the County Auxiliaries.

#### OCEAN COUNTY

The Woman's Auxiliary to the Ocean County Medical Society, about which a reporter cannot be over modest—has come a long way in establishing itself firmly upon the foundation of coöperation, courage and durability. Its aims are primarily those of the State Auxiliary, namely to foster a better understanding and friendship among physicians' families and to aid the county society as it wishes to be aided. This, I believe, we have accomplished.

Among our more tangible projects is the Ocean County Transfusion Fund, to which we are the major contributors, pledging ourselves annually to an amount of \$100.00. This is a self-perpetuating fund which has a number of contributors in addition to ourselves. The fund pays all donors, heretofore unpaid. We contribute to the Red Cross in money and services. The county hospitals, Paul Kimball and Beach Boro Hospital, also receive at the close of each year substantial contributions from our funds.

The meetings of our group are held on the

first Friday of each month, from October to June inclusive. Our officers are installed in June. So far as possible we try to adhere to the program set down by the State Auxiliary and where adapted to our particular situation, we find the plan successful. When necessary we adapt the State plan to conform to our needs.

This year we have individually and collectively devoted ourselves to the effort of winning the war in the effective and speediest way set forth by our national governmental agencies. We trust that our report next year will bear witness to the good results of that effort.

Many of our physicians have been called to the armed forces and we have in view an even more depleted civilian medical group in this county. In order that these men may return to a worthy community and family life, we pledge our complete and unified effort.

MRS. EMANUEL M. SICKLE, President,  
Ocean County Auxiliary.

#### PASSAIC COUNTY

"P", the letter standing for Passaic County, is unique in itself that it stands for and is the beginning of many splendid self-explanatory words to base our County Auxiliary work on in the future.

*Participation* in all activities to which our members belong: Woman's Clubs, Hospital Auxiliaries, Parent-Teacher Associations, College Clubs, Literary Groups, Music Groups, Civilian Defense and in all branches of Red

Cross services, which provide a large fertile field in which to spread our work, and we have had splendid coöperation.

*Preparedness* in every way is our aim—through Nutrition Lectures, Mental Hygiene Talks, First Aid courses, Civilian and Medical Defense courses, and also through our Health Essay contest held in the elementary schools.

*Public Relations* has been stressed constantly throughout the year; posters have been distributed to encourage the public to tune their radio in on the weekly health talks given

by the County Medical Society; Health Day has been celebrated by exhibits, posters and talks on health topics.

*Philanthropy* by contributing to worthwhile and deserving charities, by establishing a \$400.00 fund, through our first supper dance, held in honor of "Doctor's Day". This money is to become the nucleus for a "Student Nurses Loan Fund".

MRS. ALFRED D. MENEVE, President,  
Auxiliary to the Passaic County Medical Society.

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## WARREN COUNTY

The Woman's Auxiliary to the Warren County Medical Society was organized in 1936. There had previously been such an organization, but due to lack of interest and coöperation it was given up, and quite some years elapsed until the present one was organized. We have at this time a membership of sixteen.

Our Society's aim is largely social, but in the past few years we have given donations to Warren Hospital, which is the only hospital in the county. At present we are working for a fund of \$300.00 to furnish a room in the new wing now being built. The community recently completed a successful drive for \$125,000 for this purpose. A number of our Auxiliary members helped with this work. We hope to meet our quota by a series of house parties and the sale of old newspapers, magazines, tinfoil and paste tubes. We sold chances on a \$25.00 Defense Bond from which we realized \$106.55. In less than a year we have built our fund from \$30.00 to \$211.00. Our method of raising funds is also of vital im-

portance to the government, so therefore serves a two-fold purpose.

We feel that by assisting the local hospital we are also aiding the nation. The hospital is of vital importance to the community at all times, but more especially now when there is an emergency. A number of our members are active in First Aid, Nurses Aid and Defense Council, and we have volunteered our services in the sale of Defense Bonds and Stamps.

More than anything else, our Woman's Auxiliary has brought about a closer relationship and good fellowship among the doctors of the county. Four times a year we meet at the same time and place, and we have luncheon with the doctors. They look forward to those meetings as much as the ladies do.

Every member of our County Auxiliary is willing to assist the Medical Society in any way they may desire in this time of America's need.

MRS. FLOYD A. SHIMER, President,  
Warren County Auxiliary.

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## Atlantic County

Mrs. Matthew Molitch, Chairman of Publicity

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday evening, May 15, 1942, with Mrs. Morton Major presiding. There were 26 members present.

Annual reports were received from the chairmen of all standing committees. The election and installation of officers for 1942-43 took place. The following are the officers for the coming year:

President, Mrs. David B. Allman

President-Elect, Mrs. G. Ruffin Stamps

First Vice-President, Mrs. Clarence B. Whims

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## Camden County

Mrs. James N. Barroway, Chairman, Press and Publicity

Mrs. George B. German, President of the *Camden County Medical Auxiliary*, entertained the members of the Executive Board at a delightful luncheon at her home on April 7th, 1942. There were twenty members present.

Following the luncheon, reports were received from the committee chairmen and plans were completed for the Annual Meeting and Luncheon to be held on Tuesday, May 5th, 1942. This year it will be held at the home of Mrs. Irwin Deibert in Edgewater Park. Mrs. Robert S. Gamon, Hospitality Chairman, and her committee have planned a catered luncheon. Dr. John A. Bornemann, an



authority on plants, will speak on "Plants and Herbs and Their Relation to Medicine".

Mrs. Gorden West, Membership Chairman, announced a total of 113 members.

Plans were made to distribute the receipts from our card party and fashion show among the following organizations: The Camden County Tuberculosis Society, Home for Friendless Children, Y. W. C. A., Maternal Welfare Society, Cancer Control, and the Needlework Guild.

An Auditing Committee was appointed, consisting of Mrs. Joseph Roberts, Chairman; Mrs. A. L. Stone and Mrs. Thomas McConaghy.

### Gloucester County

Mrs. C. A. Bowersox, Chairman Public Relations, Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held at the Woodbury Country Club, Thursday evening, April 16th, at 9 p. m., with the President, Mrs. Paul M. Pegau, presiding.

Reports from the Secretary, Mrs. Herman Wright of Pitman, and the Treasurer, Mrs. William Harris of Mullica Hill, were given.

Mrs. Fred Wandall of Clayton, Program Chairman, gave a book review of "The Moon Is Down" by John Steinbeck. There were twelve members present.

### RECIPROCITY TEA

A Reciprocity Tea was held at the Presbyterian Church in Woodbury, on Friday, April 17th, at 2 p. m. Fifty members and guests were present, representing several Parent-Teachers Associations and Woman's Clubs of the county.

Mrs. Fred Wandall of Clayton, the Program Chairman, introduced the President of the Auxiliary, Mrs. Paul M. Pegau, and Mrs. Oswald Carlander of Merchantville, State President of the Woman's Auxiliary, who gave a short talk on health in relation to the needs of our present-day life.

Mrs. Wandall then introduced Miss Joan Caldwell, County Home Demonstration Agent, who gave a very enlightening lecture on nutrition.

A general discussion followed with Miss Caldwell answering many interesting questions.

Mrs. Byrnina Socolosky of Woodbury rendered beautifully three violin selections with Miss Cora Schwenger accompanying her.

Tea was served by the committee: Mrs. B. A. Livengood of Woodbury, Chairman; Mrs. Paul Burkett, Mrs. William Chalfont, Mrs. Fred Faux, Mrs. Sidney Lintz, Mrs. Harry Nelson and Mrs. Fred Wandall.

### Hudson County

Mrs. James M. Murphy; Chairman, Press and Publicity

The yearly reports were read at the May meeting, held at the Young Woman's Christian Association, Jersey City, with Mrs. Andrew Ruoff presiding. Every chairman had a progress report. The Treas-

urer's statement showed the Auxiliary to be financially stable.

Discussion of what more we might do in the war effort resulted in the appointment of a committee of three to discover what may be advisable. It was suggested that because there are many soldiers stationed in this county, we could provide some service.

Mrs. Arthur Largay, former President, received a picture of the canteen we purchased about a year and a half ago, and have given to the British War Relief Society. A letter was also received, from which was read the following: "This is an appreciative line to inform you of the splendid work that has been performed by your up-to-date Canteen bearing the inscription '*Presented by the Woman's Auxiliary, Hudson County Medical Society, Jersey City, New Jersey, U. S. A.*', now stationed at Barking, East London.

"The vehicle has done good work, such as serving food to demolition workers, making trips to isolated Anti-Aircraft, Observation and Balloon Barrage Squads and small camps.

"When raids occur, whether small or great, Salvation Army Canteens rush to the scene. Responsible authorities also greatly appreciate the timely work that these Canteens perform and the kindness and sacrifice which has made these gifts possible.

"May God guide and bless the nations now in a grim, united struggle for the defense of our Western Christian Civilization.

"Yours very sincerely,

ERNEST JELLS, Lt. Colonel,  
Salvation Army."

Mrs. Thomas Martin (Ruth Kelley), daughter of another ex-President, spoke of the first performance of the Hudson Grand Opera Association to be held Friday, May 22nd, at the Grief Theatre in Union City.

The Annual Play Day, a luncheon and bridge at Yountakah Country Club, will be held Monday, May 25th, at 1 p. m. To avoid unnecessary use of tires, members will take the regular bus.

### Passaic County

Mrs. Joseph E. Mott, Publicity Chairman

The Annual Open Meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held on April 13th at the Paterson Women's Club. Dr. Paul B. Ferrary, of the Medical Staff of St. Joseph's Hospital, was the guest speaker, his topic being "Your Diet for the Duration". The meeting was very well attended and the speaker proved most interesting and informative; particularly at this time when the nation is facing a food rationing problem. Tea was served in the club dining room following the lecture. Mrs. Richard J. McDonald and Mrs. William A. Dwyer poured. Mrs. Michael L. Keller was general chairman.

The Auxiliary will close its current season with a luncheon affair at the North Jersey Country Club on May 18th at which time the new officers will be presented. Mrs. M. Dobson of the Clifton Red Cross will be the principal speaker.

## BOOKS RECEIVED FOR REVIEW

**ELECTROTHERAPY AND LIGHT THERAPY**, with the essentials of hydrotherapy and mechanotherapy. By Richard Kovacs, M.D. 4th ed. Pp. 735. Philadelphia, Lea & Febiger. 1942. \$8.00.

**ELECTROCARDIOGRAM AND X-RAY CONFIGURATION OF THE HEART**. By Arthur M. Master, B.S., M.D., F.A.C.P. 2d ed. Pp. 404, illus. Philadelphia, Lea & Febiger. 1942. \$7.50.

**CARCINOMA AND OTHER MALIGNANT LESIONS OF THE STOMACH**. By Waltman Walters, B.S., M.D., M.S. in Surgery, D.Sc., F.A.C.S.; James T. Priestly, B.A., M.D., M.S. in Experimental Surgery, Ph.D. in Surgery, F.A.C.S., and associates in the Mayo Clinic and Mayo Foundation. Rochester, Minn. Pp. 576, illus. Philadelphia, W. B. Saunders Co. 1942. \$8.50.

**MANAGEMENT OF THE SICK INFANT AND CHILD**. By

Langley Porter, B.S., M.D., M.R.C.S. (Eng.), L.R.C.P. (Lond.), and William E. Carter, M.D. 6th ed. Pp. 977. St. Louis, C. V. Mosby Co. 1942. \$11.50.

**SYNOPSIS OF ANO-RECTAL DISEASES**. By Louis J. Hirschman, M.D., F.A.C.S. 2d ed. Pp. 315. St. Louis, C. V. Mosby Co. 1942. \$4.50.

**EYE MANIFESTATIONS OF INTERNAL DISEASES**. By I. S. Tassman, M.D. Pp. 542. St. Louis, C. V. Mosby Co. 1942. \$9.50.

**PATHOLOGY OF THE ORAL CAVITY**. By Lester Richard Cahn, D.D.S. Pp. 240. William Wood, The Williams & Wilkins Co. Baltimore. 1941. \$5.50.

**SYNOPSIS OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY** for students and practitioners of medicine. By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B. 2d ed. Pp. 695. St. Louis, C. V. Mosby Co. \$5.57.

## BOOK REVIEWS

**Perineopelvic Anatomy from the Proctologist's Viewpoint**: By R. V. Gorsch, A.B., M.D. Pp. 298. New York, The Tilghman Company. 1941. \$8.00.

For over seven years, prior to Colonel Gorsch's service with the army, this reviewer had the privilege of being associated with him in the Proctologic Department of the Polyclinic Post-Graduate Medical School and Hospital. He was impressed with the teaching ability of the author.

To most of us anatomy has always been a difficult study to absorb, but as presented by the author to the post-graduate students, it was a fascinating subject and a valuable addition to proctologic knowledge.

The volume under review embodies all of the proctologic anatomy he taught and a great deal more, culled by the author from the literature. The latter is evidenced by the exhaustive bibliography at the end of each chapter.

The book should be in the library of all surgeons for many neglect this important branch of anatomy. Without a proper knowledge, surgery of this area is often haphazard and conducive to catastrophic results. A painstaking perusal of this book with the assistance of the profusely illustrated photographic reproductions of anatomical dissections, clearly labeled, will result in a thorough knowledge of the ano-rectal anatomy. It will result in confidence in performing much of the intricate surgery of this region.

The subject matter does not lend itself readily to an elaborate review. It will suffice to state that this all-inclusive volume brings together, up to date, the material which is usually found in fragmentary descriptions in most text books of surgery.

Time will undoubtedly place it where it belongs, as a classic in the practice of the complex specialty of proctology.

JULIUS GERENDASY, M.D.

**The Toxemias of Pregnancy**. By William J. Dieckmann, M.D. Pp. 521. St. Louis, C. V. Mosby Company. 1941. \$7.50.

The author has written his book with two ideas in mind; namely, to collect the recent contributions on physiology in obstetrics, and give a resumé of the physiology and pathology, both for the obstetrician and for those not practicing exclusively in this field.

He classifies the toxemias, and describes in detail many physical and chemical standards of the body and the variations which they undergo during pregnancy and its toxemias. A historical resumé of the treatment of eclampsia is presented, and an entire chapter is devoted to the hypnotic, anesthetic and sedative drugs used in toxemia. The various methods of termination of pregnancy in the toxemias are evaluated and the obstetric treatment is discussed in detail. The physiology of the kidney in the non-pregnant, pregnant and toxic individuals is reviewed and the results of the various renal function tests used in toxemic patients both before and after delivery are given in detail.

All phases of this problem of toxemia are thoroughly discussed, and the book is a valuable addition to the literature.

RICHARD BROWN, M.D.

**Diseases of the Blood and Atlas of Hematology**, with clinical and hematologic descriptions of the blood diseases including a section on technique and terminology. By Roy R. Kracke, M.D. 2d ed. Pp. 692. 54 color plates. Philadelphia, J. B. Lippincott Co. 1941. \$15.00.

This is the second edition of an unusual book. The first edition in 1937 was outstanding but as time went on, required the extensive revision that has been accorded this volume. All this has been done most masterfully and the highest praise must

be given to the author for his own work and to the associate and contributory authors.

It is remarkable that so much information that is both elementary and advanced has been compressed into less than 700 pages. There is material for the specialist hematologist as well as the student and the practitioner. The stress made on technique is interestingly presented. The reviewer is of the same opinion that a good and distinct technique is vital to the study of blood dyscrasias and there are not words enough to express the necessity for this.

The clinical material is lucid and presented in a most instructive manner. For example, the section on bone marrow gives the actual differentials found in the cases illustrated. The descriptions of the various dyscrasias are also lucid and do not contain too many generalities.

Comment might be made about the section on the bone marrow. The material has been written by Dr. Custer and very ably presented. However, there is so much variation about the terminology of the types of cells as listed by the various workers that the illustrations do not satisfactorily illustrate the conditions. It is realized that good pictures are difficult to reproduce, not only to photograph. It is difficult to distinguish the separate types of cells found in marrow. It is moreover assumed that the reproductions are of paraffin sections, and not of touch smears.

In conclusion, this book is recommended to every practitioner and student of hematology and should remain a standard text for some time to come.

MURRAY W. SHULMAN, M.D.

**In Defense of Children.** By Bert I. Beverly, M.D.  
Pp. 228. 10 line sketches. John Day Publishing Co., New York. 1941. \$2.00.

Dr. Beverly's title is well chosen since it is his conviction that the failure of parents to understand mental growth and development is the cause of much of their unnecessary concern regarding their offspring. The child is, in the great majority of instances, reacting quite normally to conditions past or present and of which the parent is quite unaware. The parent is advised to watch the growth and development of his child as an interesting and instructive study from both the physical and mental sides. Dr. Beverly advises the parent to do nothing when he is in doubt as to the correct procedure at any time. The author asserts that the compelling motivation must be created within the child, and praise is claimed to be far more effective than censure for this purpose. The first six months of life are most important because the rate of growth and development are greatest at this time. Dr. Beverly asks that in all fairness the parents offer food but do not force-feed their child; that parents recognize and respect the emotional rights of their child, especially since his mental

development, though normal, does not permit abstract reasoning, and what he does is generally approved by his playmates and the understanding pediatrician. Parents are told that example is more effective than precept in achieving "good behavior" and this word "good" is not to be measured by the criterion of adult behavior. Self-discipline is the best form, but also apparently the most difficult for most parents to develop in their own children. The author discusses speech defects and their cause, left-handedness and its relative insignificance, adolescent problems, food habits, educational problems, elimination and those many things which daily, and often unduly, concern the parents, especially the mother.

This book is enthusiastically recommended by the reviewer as confirming in large measure his own experience as a parent and pediatrician.

LEROY A. WILKES, M.D.

**Röntgen Treatment of Infections.** By James F. Kelly, M.D., F.A.C.R., and D. Arnold Dowell, M.D. Pp. 432. Chicago, Year Book Publishers, Inc. 1942. \$6.00.

This book is an honest attempt to evaluate the use of x-ray in the treatment of infections. The roentgen ray is well established in the treatment of malignancy and skin diseases. There has been a great deal of reluctance in the acceptance of its uses in the treatment of infections but it is gradually winning recognition in this field.

No little credit for this is due to Dr. Kelly for he pioneered in its use in the treatment of gas gangrene and developed the mobile therapy unit which can be taken to the bedside of the patient. In this book the development of the work is traced; 439 cases of gas gangrene are reported and analyzed critically, with 51 cases of peritonitis. A chapter is devoted to each of the following: Superficial and other infections, parotitis, mastoiditis, and pneumonia.

A portion of the book is devoted to a consideration of contraindications to x-ray therapy. This part also contains a comprehensive review of the literature; list of contributors and bibliography.

The book is well worth the attention of all surgeons and all those who have to deal with the care and treatment of those infections. The authors are very conservative in their statements. As subjects are presented, there are numerous case histories used to give one an idea as to the probable results likely to occur under different conditions. The authors freely discuss their failures as well as their dramatic results. This book should be well received by all those interested in the treatment of infections.

W. JAMES MARQUIS, M.D.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

June, 1942

No. 6

SUCCESS in the use of chemotherapeutic agents in combating infectious diseases revived the hope that eventually a substance will be found that will be useful clinically in the treatment of tuberculosis. Promin, one of the compounds used experimentally, has already been discussed in the public press. Abstracts of the article announcing the results obtained in animals with this chemical follow:

### PROMIN IN THE TREATMENT OF TUBERCULOSIS

In 1938, sulphanilamide was reported to have an inhibitory effect on the development of experimental tuberculosis in guinea pigs but subsequent papers held out scant hope that this agent would prove to be a specific remedy for tuberculosis in human beings.

Promin in its solid form varies from white to light yellow and is slightly hygroscopic. It is highly soluble in water and 40% solutions are stable indefinitely and may be sterilized by heat. It is slightly bitter but small amounts may be mixed with the food of animals without impairing their appetite or digestion. Guinea pigs tolerate one per cent promin in their foods and will consume from 300 to 400 mg. of the drug per 24 hours. Increasing the concentration of promin to 2%, causes anorexia which interferes with the quantity of food taken.

In the first experiment, promin to the amount of one per cent was added to the feed of 30 guinea pigs while 20 others received the same diet but without promin. Two days after the feeding experiment began, all guinea pigs (50) were inoculated subcutaneously with human tubercle bacilli of known strain. On the 84th day all the animals in the control group had died and 24 of the animals which had received promin were living. Promin was then removed from the diet of 12 of the survivors. After 82 days more, 13 animals still lived, five of which had received promin for the entire period (166 days) and the other eight for the first period of 84 days only. The purpose of this procedure was to determine if latent tuberculosis would become reactivated when treatment was discontinued.

The value of a chemotherapeutic agent must

be appraised not only on survival time, but also on the character of the disease process. With one exception the degree of tuberculous involvement in the animals that received promin was notably less than in the controls.

Although the results indicated that in many of the animals promin either had prevented the establishment of lesions or had caused their eventual disappearance, another effect of the drug which is perhaps of more importance was that which it exerted on the cellular elements of the lesions. In the vast majority of the animals in the treated group that had lesions, the histopathological characteristics of the disease process apparently were modified favorably. This was especially true of the lesions in the parenchymal tissues. The lesions were usually small and discrete and the epithelioid phase of the reactive process predominated. Necrosis was infrequent and a tendency of the process toward fibrosis was observed frequently. These features of the morbid process were in marked contrast to those that characterized the disease in the control group of animals. In the latter the disease was extensive, destructive and progressive.

The objectives of the second experiment were: (1) to confirm results of the first and (2) to determine what effect, if any, promin might have on a tuberculous infection introduced at the same time as or at varying periods before treatment with promin was begun.

Eighty guinea pigs were selected and divided into 8 groups. Group one consisted of 12 animals infected but not treated (controls). Group 8 consisted of 20 animals whose treatment began two days prior to infection. Groups 2 to 7 each con-

tained 8 animals and treatment was begun, in relation to the day of infection, at various intervals as follows:

- Group 2—day of infection
- Group 3—3 days after
- Group 4—one week after
- Group 5—2 weeks after
- Group 6—4 weeks after
- Group 7—6 weeks after

All animals (one exception) reacted to tuberculin. Generally speaking, the reactions of the animals that received promin were less severe than those of the untreated animals.

While the general physical condition of the animals remained satisfactory, changes indicative of toxic manifestations were noted in the blood and spleen. Studies, as yet incomplete, indicate that in guinea pigs, promin may induce a hemolytic type of anemia but with adequate regeneration as indicated by a corresponding reticulocytosis.

The difference in survival times of the several groups was striking. When the last of the untreated animals died, 189 days after inoculation, 84% of the treated animals were still living. Of the treated animals that died, none had sufficient tuberculosis to account for death, and this percentage of deaths might reasonably be considered an average or normal mortality rate for guinea pigs.

Examination of the tissues and organs of the animals showed that all untreated animals were tuberculous, that in 57% of the treated animals no evidence of infection in the visceral organs was found, that in the remainder of those treated tuberculosis was found (with a few exceptions) of minimal severity and that 43% of the treated animals failed to show evidence of disseminated tuberculosis.

The failure to demonstrate lesions of tuberculosis in a considerable number of the animals that were treated and the further fact that the disease in the treated animals was, with few exceptions, minimal and nonprogressive indicate that the action of the drug was significant. That fairly comparable results occurred in the treated animals, regardless of whether the administration of the drug was started before or as long as four or six weeks after inoculation with tubercle bacilli, was surprising and must indicate that the drug was effectively operative against a tuberculous infection in which morbid changes already were established when administration of the drug was started.

The conclusion of the two experiments is that promin had a deterrent effect on experimental tuberculous infection.

*Promin in Experimental Tuberculosis, Wm. H. Feldman, M.D., H. Corwin Hinshaw, M.D., and Harold E. Moses, M.D., Amer. Rev. of Tuberc., March, 1942.*

ENCOURAGED by these carefully controlled animal experiments, promin has been used guardedly in the treatment of a few cases of tuberculosis in human beings. Administration of the drug has proved difficult since its toxic effect in man is found to be much higher than in the guinea pig. In certain cases it has been found necessary to discontinue treatment because of unfavorable symptoms attributed to the drug itself. In other cases where treatment has been prolonged (5 months or more) results thus far show varying effects. In a few, definitely demonstrable improvement occurs; in others little or no change is observed; while in some patients, the disease goes on developing progressively with no apparent effect from the treatment.

It is obvious that a freshly infected guinea pig presents a very different pathological picture from that of a well developed human case with destruction of tissue and extensive fibrosis which interferes with access of the drug to living tubercle bacilli.

Despite the present lack of convincing evidence of promin's value in the treatment of human tuberculosis, there appears to be a definite feeling that further trial in skilled hands is indicated.

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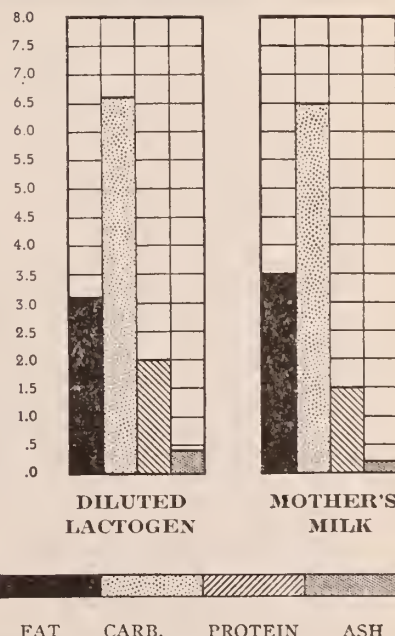
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Clinical Pediatrics, p. 156.



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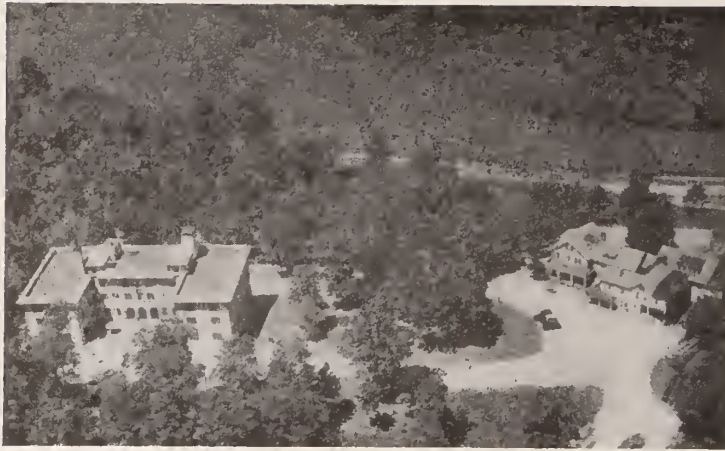
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Manuscripts are accepted on the assumption that they are contributed solely and exclusively to this *Journal*.

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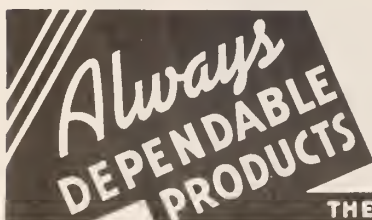
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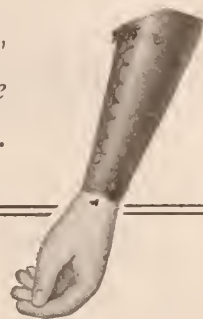
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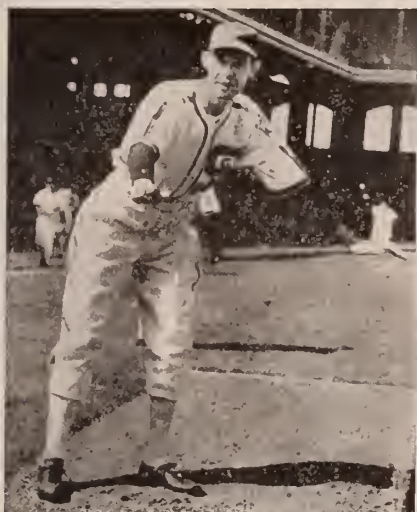
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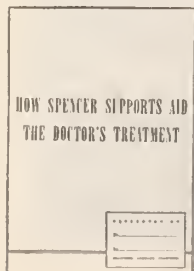
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Clinical observations of Strauss and McDonald lead to the conclusion that the condition is a dietary deficiency disorder similar to beriberi, caused by lack of vitamin B<sub>1</sub>. They report recovery in their cases receiving this therapy, including dried brewers' yeast.

## *Hyperemesis as Cause of Avitaminosis*

Wechsler observes that all cases of polyneuritis of pregnancy recorded in the literature were preceded by long periods of severe vomiting. "It would seem," he adds, "that because of actual starvation these patients suffered from avitaminosis and consequent neuritis," a view likewise held by Hirst, Luikart, and Gustafson. Plass and Mengert observe that the practice of giving high carbohydrate feedings for hyperemesis gravidarum is still more likely to cause avitaminosis.

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### CONTENTS—Pages 361-414

#### EDITORIALS—

	Page
ATTENTION: PHYSICIANS .....	361
GETTING RESULTS .....	362
MEDICAL CLINIC SERVICE .....	362
A PROPHECY .....	363
HEALTH INSURANCE .....	363
EXCHANGE OF VIEWS .....	364
WHAT IS THE MEDICAL SOCIETY DOING WITH MY DUES? .....	364

#### THE WAR—

PROCUREMENT AND ASSIGNMENT—Frank H. Lahey, M.D. ....	365
Civilian Medical Practice on a War Time Basis .....	365
Decontamination of Eyes After Exposure to Lewisite and Mustard .....	366

#### ORIGINAL ARTICLES—

THE TREATMENT OF WAR WOUNDS OF THE THORAX—Major George N. J. Sommer, Jr., M.C., Fort Dix, N. J. ....	367
URINARY TRACT PATHOLOGY ASSOCIATED WITH CARCINOMA OF THE CERVIX—Irwin Markowitz, M.D., F.A.C.S., and J. D. Katz, B.S., M.D., Jersey City, N. J. ....	373
A CASE OF HYPOPHYSEAL DEFICIENCY RESEMBLING SIMMOND'S DISEASE—Thomas P. Prout, M.D., and Carroll S. Thomson, M.D., Summit, N. J. ....	376
THE ITCH TO WRITE—Henry A. Davidson, M.D., Newark, N. J. ....	380
BILIARY DYSKINESIA—A. J. Barbano, M.D., New Brunswick, N. J. ....	383
RECOVERY FROM CEREBELLAR ABSCESS OF OTOGENIC ORIGIN (Report of a Case)—Albert F. Moriconi, M.D., Trenton, N. J. ....	385
A LESSON FROM A DEATH CERTIFICATE .....	386
THE TREATMENT OF RECURRENT AND THREATENED ABORTION. Maternal Welfare Article No. 71—William J. Carrington, M.D., Atlantic City, N. J. ....	387

#### STATE ACTIVITIES—

	Page
The A.M.A. Meeting in Atlantic City .....	391
Medical-Surgical Plan of New Jersey .....	392
The New Jersey Tuberculosis League—B. S. Pollak, M.D. ....	393
The Edward J. Ill Award—Citation by Dr. Wells P. Eagleton .....	396
With New Jersey Medical Authors .....	396
"Well Done Thou Good and Faithful Servant"—The Ill Award to Dr. E. Zeh Hawkes .....	397
Supplementary List of Members .....	397
Members Serving in the Armed Forces .....	398
Neonatal Deaths in New Jersey in 1940 .....	398
Medicine Faces the Future .....	400

#### OBITUARIES—

Dr. Edward J. Ill .....	402
Dr. William W. Beveridge .....	402
Physicians Deceased in April .....	402

#### BULLETIN BOARD .....

#### COUNTY SOCIETY REPORTS—

Atlantic, Burlington, Camden .....	404
Essex .....	405
Hudson .....	406
Middlesex, Monmouth .....	407
Morris .....	408
Passaic .....	409
Somerset, Summit Medical Society .....	410

#### WOMAN'S AUXILIARY—

Camden Auxiliary Report .....	410
-------------------------------	-----

#### THE BOOK SHELF .....

#### TUBERCULOSIS ABSTRACTS .....

Roster of Officers, Advertising Page 3a

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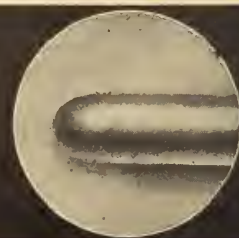
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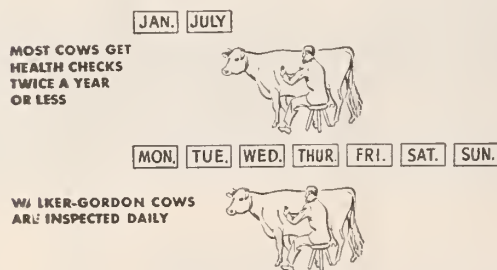
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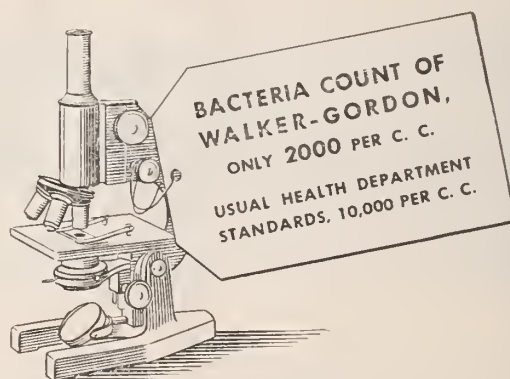
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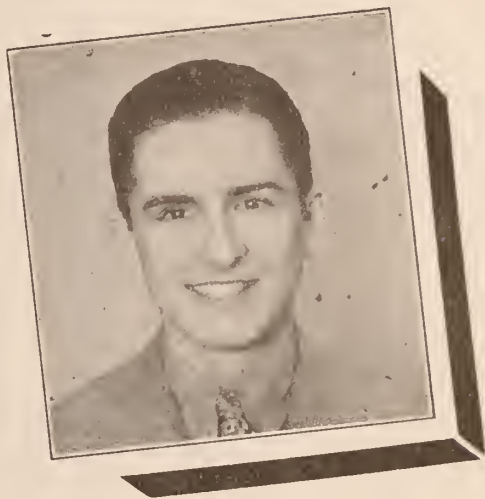
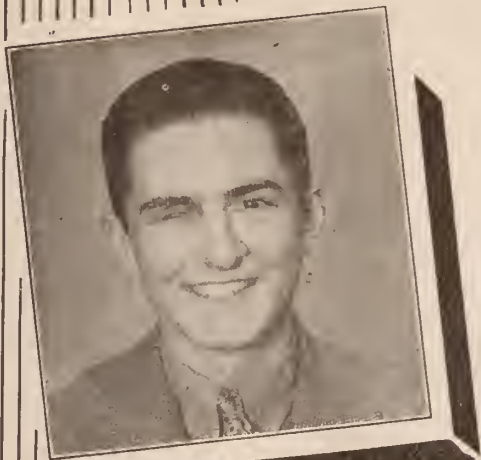
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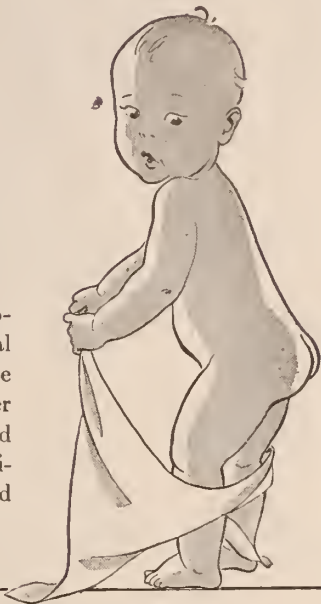
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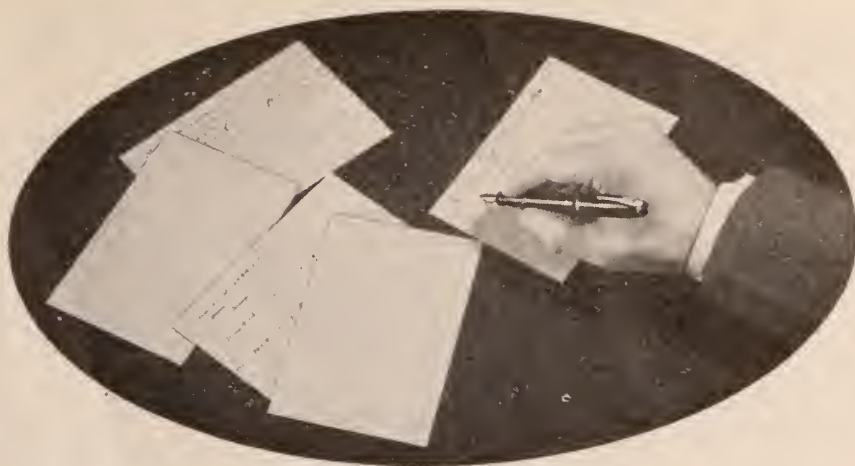
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\**J.A.M.A.*, 93:1110—October 12, 1929  
*Brückner, H.—Die Biochemie des Tabaks*, 1936

\*\**The Military Surgeon*, Vol. 89, No. 1, p. 5,  
July, 1941

\*\*\**ibid.* p. 5

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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154. *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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Brand of amphetamine sulfate



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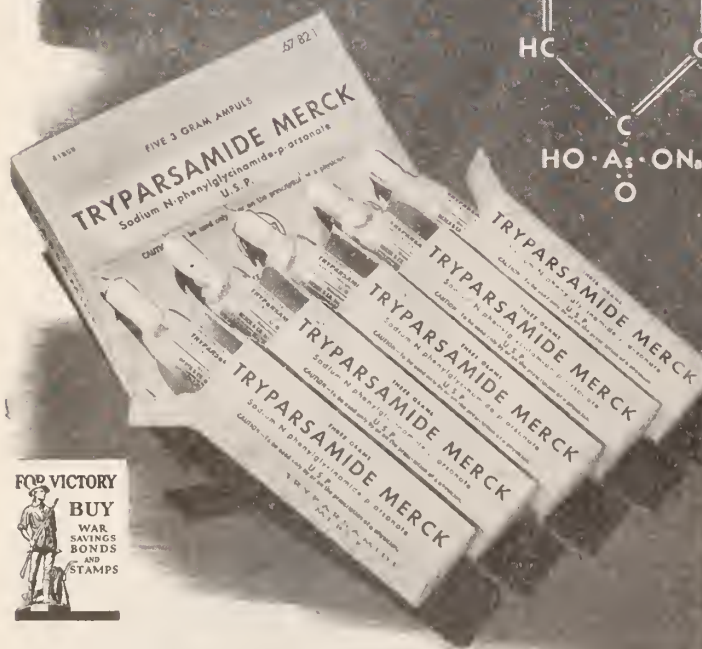
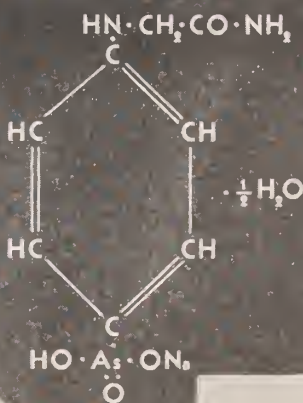
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therapeutic agent  
in neurosyphilis*

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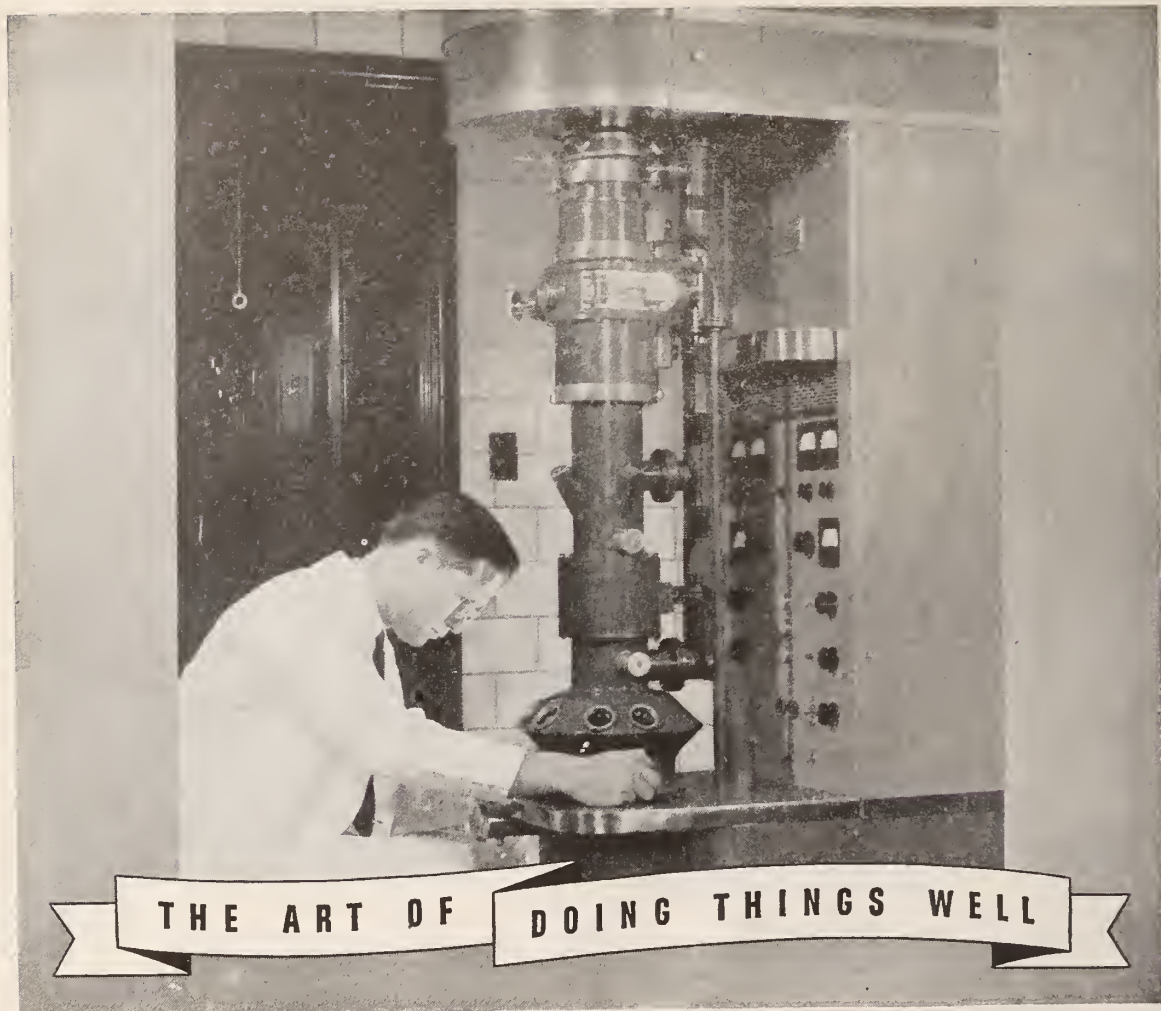
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# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

Whole Number of Issues, 455

UNDER THE  
DIRECTION OF THE  
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor  
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JULY, 1942

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## ATTENTION: PHYSICIANS

### I

In the Journal of the American Medical Association of June 27th, there is a statement by Paul V. McNutt, Chairman of the War Manpower Commission, entitled "The Procurement of Physicians". Every member should read this article, of which the following extracts are an example:

"\* \* \* I stated bluntly the fact, which could not have been evaded by analysis, that unless voluntary recruitment progresses more rapidly, some more vigorous form of selective service must be resorted to."

"\* \* \* These facts are necessary in order to permit the medical profession to diagnose its own case. And the case is urgent; physicians are members of what is probably the most indispensable of all professions. \* \* \*

"\* \* \* We need more than twenty thousand additional physicians by the end of this year. \* \* \*

"\* \* \* The seriousness of the deficit in the number of physicians available for the armed forces must not be underestimated. The need must be met. *It will be met* by one method or another. \* \* \*

"\* \* \* Eight states—New York, Illinois, California, Pennsylvania, Massachusetts, *New Jersey*, Michigan and Ohio—must supply most of the physicians needed for the armed forces at this time. \* \* \*

Dr. Frank Lahey, Chairman of the Directing Board of Procurement and Assignment Service, in a letter to physicians urges increased enlistment of physicians, not only for the care of the armed forces, which is largely a job for physicians under 37 years of age, but the need for others to make themselves available for

the maintenance of essential hospital service and medical service for civilian population needs in urban, county, state and national health departments and in industry. He quotes Mr. McNutt as having repeatedly emphasized that the medical profession has shown the way to the scientific study and allocation of manpower in this emergency. We must continue to merit this extraordinary compliment.

## II

In an editorial in *Hygeia*, in its July issue, the import and meaning of morale is discussed. This editorial stresses the close relationship between a low state of morale and weak or failing physical, mental and social health. This applies not only to those who are to fight, but also to those for whom our armed forces are fighting.

---

## GETTING RESULTS

Your Executive sat in a N. Y. A. Conference as a member of an Advisory Committee to discuss the War Effort and the part N. Y. A. students play in it. Above all else the N. Y. A. boys and girls must be *producers*, and they must do at least one thing *well, fast and persistently*—and maintain the standard of quality and performance. This is a new experience for many of our youths. The “easiest way” has no place in a war production program—and it will probably play a very small part in the successful meeting of the competition with which we will be faced after the war. The peacetime vocational schools place *educational*

objectives first, but the N. Y. A. emergency training has properly viewed its assigned task as keeping the *production* objective foremost in its efforts. The practical men who are training these youths have themselves already shown their own ability to deliver the goods, and they are exerting a refreshing and very wholesome influence on the youths with whom they work. Their example fits in well with the precepts they expound. Such teaching and leadership will produce results. The boys and girls at work in the N. Y. A. shops look as though they are proud and happy to meet the challenge of such leaders.

---

## MEDICAL CLINIC SERVICE

A physician from Homer City, Pa., sends in a suggestion that merits consideration as the available supply of civilian physicians dwindles through war demands. For those who must seek medical service without cost to themselves and must look to others to pay the cost, this physician suggests the *clinic type* of service with paid staff—rotated if need be to spread this service over the available doctors so as to relieve the load on any one physician. This clinic service might be diagnostic or consultant for the more severe cases.

In every organized effort for groups, the clinic type of group service is always proposed by someone. It originated as the physicians' own plan for caring for indigent groups in an economic and effective way. There is no such thing as free service—someone pays. Government is rapidly replacing private philanthropy as the one remaining source of funds, and organized medicine must be ready with a *workable* indigent care plan to which money will be contributed by the public through taxation for its cost of operation including the honoraria of the professional personnel.



## A PROPHECY

In recent addresses Vice-President Wallace, Anthony Eden, Nehru, Morrison, the British labor leader, and Sir Stanford Cripps have prophesied with remarkable unity, the essential considerations which will determine whether we shall safeguard ourselves and a world which will provide peace, liberty and plenty—or whether we shall blindly repeat the experiences through which we are now passing as a result of personal ambition, greed and a total disregard for human life and happiness.

The leaders of the Axis Powers, in the interval since the First World War, have applauded and applied the latter principles and practices, all of which the Allied Nations abhor. The Allied leaders are

already thinking of the problems of the post war era, and, as one man, they stress the fact that this is a *people's war*. The material destruction can be replaced in large part, or rebuilt on an even grander scale. Starvation can be conquered, and liberty and justice can be restored to nations as well as to individuals. The new goal is *service to mankind*, under any form of government which a nation may choose for itself which will not interfere with the rights of another nation.

The day of the *empire* is over. A workable World Federation, founded upon truth and implemented with police power and courts of justice, is gestating in the minds of the appointed leaders in all the Allied Nations. Physicians too will do their part in carrying out this effort.

---

## HEALTH INSURANCE

Health Insurance, as demonstrated in Europe, may be considered an improvement in their lot by its beneficiaries who know only *limited* opportunity, long and arduous hours of work at inadequate wages, few and simple recreations and diversions, and a long-existing but stymied longing for those things which the American working man enjoys in abundance.

Health cannot be "insured". Its preservation is largely the result of *personal practice* rather than legislation or information, both of which are of value only when they result in desirable and healthful habits in the individual.

After the restraints of wartime it is likely that we Americans will again long for personal liberties to pursue happiness as we formerly did with considerable success and on our own initiative. *Opportunity* can be provided but *achievement* itself still rests upon the individual, and no safer basis for reward has ever

been provided than that founded upon "getting things done well and promptly".

Let us return to the typical "American Way" of emphasizing our obligations before our "Rights", our opportunity to earn our just rewards, fairness in our dealings with our fellow-men. With these basic considerations agreed upon we can and should persist in our endeavor "to better distribute medical services to all in need thereof at a cost which each can pay" and to approach this important problem with an open mind rather than a set pattern to defend. The following factors are quite typically American: Organized effort, distribution of costs through increased service and persons benefitted, economy of time, effort and material resulting in lowered cost per person or per service and increased demand and supply.

These can all be successfully applied in the distribution of service whether medical or other type. New ways are not

always best, but some of the new ways may be better than the old. We need more willingness to plan and experiment to get the facts before we make our final decisions.

The doctor's opinion on *professional* aspects of illness and accidents is still our best guide. But *facts* will determine the patient's satisfaction and the cost he is willing to pay for it.

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### EXCHANGE OF VIEWS

People do not take kindly to volunteered advice. It makes very little difference whether such advice be given by an individual or by a professional group. It may be diplomatic to express an idea in the form of a question to have it considered by others—often favorably. A statement put forward in question form suggests merely an exchange of views. Other questions are raised in the ensuing discussion. Through mutual exchange of views and the resulting discussion, working

agreements can frequently be reached and reciprocal confidence established. Even when the advice is voluntarily sought and is given by an authority in the given field of competence, it is flattering to the "patient" to be treated as an intelligent person whose reaction and comment is welcomed. Even within his own acknowledged field of competence a speaker can most profitably couch his message in question form. We all like to be regarded as equals and be invited to reply.

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### WHAT IS THE MEDICAL SOCIETY DOING WITH MY DUES?

Every physician in New Jersey can find the answer to this question in the Annual Reports published in the April *Journal*, and in the August supplement of the Transactions of the 1942 Annual Meeting. Every physician should be aware of the fact that the tempo of all activities is being greatly speeded up and *time* has become an important consideration with regard to our accomplishments. It is no longer possible to prolong discussion and debate upon each issue. The capacity for *action and decision are the criteria* by which men are selected in any crisis. We must do the best we can *now*—or others will replace us to carry on.

When the great number of our members eventually return from the war, they will be fully trained in *organized effort* and only those who can play their full

part in teamwork are assured of a place in the projects which will be forthcoming to restore men and materials to their full usefulness. There will be individual practitioners of the medical art, of course, but they will be fewer and they will have to be better than average to command patronage by those who require the best. The less competent and lazy fellow will have to speed up or be left behind—possibly hopelessly so.

Did you hear or read Dr. Lewis' talk at the annual banquet in Atlantic City this year? If not, look for the August *Journal* Transactions supplement. Dr. Lewis states that changes are inevitable—and he is very likely to be right. Times *do* change and competition gets keener. Those who delay or fall behind the trends of the times are likely to lose ground.

# THE WAR

## PROCUREMENT AND ASSIGNMENT

OFFICE FOR EMERGENCY MANAGEMENT  
WAR MANPOWER COMMISSION  
WASHINGTON, D. C.

Chairman  
PAUL V. McNUTT

*Federal Security Administrator*

Procurement and Assignment Service for  
Physicians, Dentists, and Veterinarians

June 24, 1942.

### MEMORANDUM

To: State and Corps Area Chairmen  
Procurement and Assignment Service

Subject: The Assignment of Physicians to  
Meet the Needs of the Armed  
Forces for 1942

At its meeting on May 18, 1942, the Directing Board of the Procurement and Assignment Service authorized the following procedures to supply the needs of the armed forces for physicians up to December 31, 1942:

1. A quota which each State should supply has been computed, taking into consideration the physician-population ratio in that State and the number of physicians already commissioned therefrom.

2. All new commissions issued in a State will be counted toward the quota of that State, whether these commissions are issued upon voluntary application by physicians, upon applications requested by Selective Service or by Procurement and Assignment Service, or upon contacts made by the special Recruiting Boards for medical officers.

3. Physicians who have enrolled with the Procurement and Assignment Service and who were in the first draft registration, that is, under the age of 36 years on October 16, 1940,

shall be called as needed to fill the 1942 requirements of the armed forces, except for those who are considered essential for the care of the civilian population by the State Committee of the Procurement and Assignment Service.

4. The names for these lists will be selected by chance, from an alphabetical list of the physicians in the State in the age group desired, utilizing first the lists of those who have indicated Army or Navy service as first or second choice and second the list of all others in the age group desired.

5. The names thus selected will be cleared through the Chicago office of Dr. Leland and the State Chairmen.

6. Those individuals who are cleared and available will be given assignments by letter to apply immediately for commission.

7. When these letters are mailed a list of the names will be furnished to the State Chairmen. The State Chairmen should at once request the State Directors of Selective Service to give consideration to the immediate reclassification of these physicians because they are not considered essential in their present situations by Procurement and Assignment Service and consequently have been requested to apply immediately for their commissions.

8. The tentative quota for the State of New Jersey is 945 from May 1 to December 31, 1942. From this total may be deducted the number of commissions issued to physicians in the State since the first of May. As later data become available on the number of physicians commissioned you will be informed. Not less than one-half of this remaining quota should be filled by August 1, the balance by December 31, 1942.

For the Directing Board,  
FRANK H. LAHEY, M.D., Chairman.

## CIVILIAN MEDICAL PRACTICE ON A WAR TIME BASIS

There seems to be both sincere and pre-  
tended confusion in the minds of physicians  
relative to their status and their obligation to  
the war effort. There is a feeling that Pro-  
curement and Assignment representatives in  
New Jersey are inclined to be arbitrary and  
unsympathetic in considering the problems of  
the civilian physician.

We feel that a few brief statements should  
assist in clarifying the situation. Let's consider  
some basic facts:

1. Every physician in New Jersey under  
45 years of age is subject to the provisions of  
the Selective Service Act.

2. Every fully licensed physician in New  
Jersey under 45 years of age who is a citizen,



a graduate of a Class A school, of good moral character and physically fit may be commissioned without undue delay as a Medical Officer in the Army of the United States.

3. Physicians not wishing to accept commissions when declared available are referred to Selective Service Headquarters and become Selective Service problems.

4. Local Selective Service Boards may, in considering the classification of a physician, take into consideration the pay and allowances which a Registrant would receive in event he is commissioned. (See A. M. A. J., May 16, page 268, par. 5.)

5. Procurement and Assignment must procure approximately 2,000 physicians from New Jersey for the service in the Army by December. This is in addition to those needed by the Navy and other Federal services.

6. To secure this quota will require that every physician in New Jersey under 45 years of age who is physically fit will be in the armed forces by December, with the exception of a very small number who will still be considered temporarily essential in their communities at that time.

7. The names of all New Jersey physicians under 37 years of age have been reported to the Chicago Office of Procurement and Assignment for "educational clearance" (June 25). They should reach New Jersey before this *Journal* reaches you. Their availability will be determined as rapidly as they can be processed through this office. When this list has been exhausted, we will receive the names of the remaining physicians under 45 years of age.

8. This will require that civilian practice go on a war basis. Older physicians must do the work formerly done by younger men. Hospitals and industrial plants must organize their

Medical Staffs on a war time basis, utilizing the services of physicians over 45 years of age or physically disqualified for military duty. The type of practice must be altered, the standards must be maintained. Yes, Sir, America is really going to war!

In a recent telephone conversation to this office, Colonel Sam Seeley, Secretary of Procurement and Assignment, said, "It's a cinch that every physician in New Jersey who is physically fit and not absolutely essential will be on active duty by December. As much as we would like to do it, we cannot send a personal letter to each physician informing him of this. Procurement and Assignment is inviting every physician under 45 years of age to report without delay to a Physicians' Recruiting Board for a physical examination and commission."

The Procurement and Assignment representatives of New Jersey, without fear of being considered arbitrary, advise physicians under 45 years of age as follows: Please put your private affairs in order as soon as possible and report to Colonel Lippold, President, of Physicians' Recruiting Board, Sussex Avenue Armory, Newark; or to Captain Metz, President of the Physicians' Recruiting Board at Camp Dix. You do not have to wait for an official call from Procurement and Assignment. To hospitals and industrial plants, we say: Put your medical staffs on a war-time basis. You cannot retain indefinitely the younger men on your staffs who are physically fit.

Let's get together. Let's not fight the inevitable. Let's not confuse a simple, clear issue which must be faced by us all—our war-time obligation to our government.

CHARLES H. SCHLICHTER, M.D., Chief,  
New Jersey Office Procurement and  
Assignment.

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## DECONTAMINATION OF EYES AFTER EXPOSURE TO LEWISITE AND MUSTARD

The Chemical Warfare Service recommends a single instillation in the eyes of a 0.5 per cent solution of hydrogen peroxide as soon as possible after contamination with Lewisite. This solution may be prepared by diluting one part of a two per cent solution with three parts of water, or one part of a three per cent solution with five parts of water. The solution usually found in drugstores is the U. S. P.

strength of 2.5 to 3.5 per cent hydrogen peroxide. A 0.5 per cent solution of potassium permanganate has also been found effective as an eye instillation following exposure to Lewisite.

The irrigation of the eyes should be carried out immediately, since delay will result in more serious injury.

## ORIGINAL ARTICLES

### THE TREATMENT OF WAR WOUNDS OF THE THORAX \*

By GEORGE N. J. SOMMER, JR., Major, M.C., Army of the United States  
Tilton General Hospital, Fort Dix, N. J.

An increased interest in the treatment of war wounds of the thorax appeared during the later years of World War I. Until this time non-interference with these wounds was the rule. Gask<sup>11</sup> has stated three reasons for this policy: (1) The favorable results of non-interference with the small caliber bullet wounds predominating in the South African War, which was fought on clean, dry ground; (2) the belief that opening the chest without some type of pressure chamber would be fatal; and (3) the thought that handling the lung would lead to fast and fatal hemorrhage. In August, 1916, Duval<sup>7</sup> took the initiative in operating immediately for severe open wounds of the thorax and for hemorrhage. His lead was followed by Gask and others. Morelli<sup>25</sup> of the Italian Army advanced the use of artificial pneumothorax to control pulmonary hemorrhage and developed some ingenious hour-glass type, inflatable rubber bags for the emergency closure of open thoracic wounds. During the present conflict an extensive literature has supplemented that of World War I regarding thoracic injuries.

The development of modern explosive missiles has greatly increased the severity of thoracic wounds. Table 1 presents data regarding the distribution of wounds according to the type of missile during several wars.

The large caliber, low muzzle velocity bullets used in the Civil War caused serious, often sucking wounds of the chest. Howard,<sup>23</sup> an assistant surgeon in the United States Army, advocated and practiced early excision and closure of the soft part wounds in penetrating chest injuries, and later aspiration to alleviate dyspnea, diminish hemorrhage, and prevent infection. His work did not at

that time receive enthusiastic support. Writing concerning the South African War experiences, Makins<sup>22</sup> pointed out the low mortality and morbidity rates of thoracic wounds due to small caliber bullets of high muzzle velocity. During this war, wounds of the heart and great vessels afforded the only exception to an almost universally favorable course, both as regards life and the non-occurrence of serious after effects. Fischer<sup>10</sup> states that the experiences in the South African War were confirmed in the Russo-Japanese War, during which the lung wounds did even better than in South Africa.

The tremendous increase in shell wounds during World War I completely changed the picture of thoracic wounds. The early application of the treatment methods successful in South Africa led to disastrous results. Goetze<sup>12</sup> wrote that wounds with an open pneumothorax resulted in a 90 per cent mortality with conservative therapy, early in the war, while with prompt surgical intervention the mortality rate fell to 60 and 50 per cent and later as low as 30 per cent. Duval<sup>7</sup> found the mortality rate of thoracic wounds in the medical department stations to be 45 per cent. In this figure he did not include the many men dying on the field of wounds of the heart and great vessels, or those dying of the late complications of wounds.

Kirschner<sup>18</sup> has presented some very interesting data from the German sanitary report of World War I regarding the incidence and results of thoracic wounds. He states that 298,000 men, 6.2 per cent of all injured, suffered wounds of the chest. Of these, 20.1 per cent died on the field and 79.9 per cent reached medical posts; of the latter 25 per cent succumbed. Penetrating thoracic wounds comprised 2.6 per cent of the total and 9 per cent

\* Presented before the General Surgical Session at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, April 22, 1942.

of the serious wounds. Thomas<sup>30</sup> has quoted similar statistics regarding 11,000,000 wounded in the English, American, French, and German armies. He says 6 per cent of all wounds were thoracic with a mortality rate of 56 per cent.

The chief causes of death as pointed out by Duval<sup>7</sup> and Gask<sup>11</sup> are hemorrhage, open pneumothorax, and empyema which largely kills the patients dying after the first forty-eight hours. Gask<sup>11</sup> states that the pleural cavity is infected by the missile or clothing carried in by it, through the parietal wound; or from the pulmonary wound, in which the missile, splinter of bone, or a portion of clothing may be retained.

In general, the treatment of thoracic wounds must be aimed at saving life and restoring the injured to health and duty. It must be recognized, however, that facilities for major surgical procedures are not available at the front line, even though efforts were begun during World War I to provide such facilities as far forward as possible. At the advanced surgical posts, selection must be made to permit operating upon the patients requiring immediate surgical care for the preservation of life. Severe hemorrhage and open chest wounds are such emergencies. Jolly<sup>17</sup> writes that in the Spanish Republican Army the less severe thoracic wounds were treated at the second echelon of surgical hospitals.

For convenience, the treatment of the various types of thoracic wounds is taken up in separate paragraphs. From this it must not be assumed that these problems customarily arise singly. Only too often the chest wounds of modern warfare are complicated of themselves and by injuries to other parts of the body. In this paper the treatment of shock and general surgical care will not be discussed.

Treatment on the battle field and in the battalion aid stations must be limited to control of hemorrhage in the parietal wounds and to closure of open wounds by firm occlusive dressings, which are safer than temporary closure of the skin by suture. Brunner<sup>5</sup> and Jolly<sup>17</sup> warn that these occlusive dressings should never be removed until all preparations for immediate operative treatment are available. Pa-

tients have been lost after removal of such dressings used to close an open pneumothorax. Under emergency care comes also the stabilizing of a crushed chest with multiple rib fractures. Morphine is a valuable drug for administration to men suffering with thoracic wounds. It must be used with care, however, in the presence of asphyxia, dyspnea, and cyanosis. Because of its interference with the cough reflex it should not be given patients with hemoptysis.

Severe wounds of the chest wall without penetration into the pleural cavity may be caused by shell fragments. These wounds may be associated with serious infections in the pectoral region, in the axilla, and in the deep muscles of the back. Bumm<sup>6</sup> points out the danger of anaerobic infections of the back muscles. The parietal wounds must be completely excised with removal of all devitalized muscle and bone fragments, and then packed open with vaselined gauze after topical application of sulphanilamide. It is not necessary to excise uncomplicated, traversing bullet wounds. Neglected, infected wounds must be adequately drained.

Traversing bullet wounds of the lungs and pleura without hemorrhage are the most favorable type of thoracic wounds and may be treated without operation with good results as shown by Makins.<sup>22</sup> His experience has been confirmed by that of more recent observers.

Even wounds caused by small missiles may have serious complications. The subcutaneous emphysema often accompanying thoracic wounds is usually not alarming. Mediastinal emphysema is, however, very dangerous. Unless otherwise relieved by open operation, a transverse incision is made in the lower neck and dissection carried downward behind the sternum with a finger to release the air; drainage is provided with a rubber tube to keep the tissues open. Tension pneumothorax, unless due to an open, sucking wound, is treated by aspiration of air. Although continuous removal of air is often accomplished by a needle introduced anteriorly, it is safer to provide drainage by means of a catheter placed intercostally with a water seal or provided with a finger cot cover to prevent entrance, while permitting the



egress of air. The catheter is less likely to damage the lung and is easier to maintain in place under trying conditions.

Severe bleeding from the lung, the intercostal or the internal mammary arteries; and open type pneumothorax, especially the sucking, are the indications for immediate surgical treatment of thoracic wounds, as originally advocated by Duval. These operations must be done at the most advanced surgical posts equipped for major surgical procedures. Roentgenographic study should precede operation. The pleural cavity should be adequately opened through the excised parietal wound or through a more suitably placed incision chosen by the operator. Blood should be removed from the pleura and the lung by suction, if available, and also any foreign bodies. Jolly<sup>17</sup> warns of the danger of prolonged search for small foreign bodies in these seriously ill patients. The pulmonary wounds are debrided, and wedge resections done if necessary for removal of necrotic tissue and foreign bodies, and then closed with sutures. Quite naturally, no time should be lost in first controlling hemorrhage from the lungs or parietes. Recently Monod<sup>24</sup> and Brodtkin<sup>4</sup> have reported lobectomies and subtotal pneumonectomy, respectively, for bullet wounds of the lung with severe hemorrhage sustained in civilian life. Monod<sup>24</sup> was fortunate enough to operate upon his patients 35 and 45 minutes after injury, and remarks upon the ease of lobectomy with normal hilar structures. At the conclusion of operation the chest wall must be carefully closed to eliminate open pneumothorax, using muscle flaps if necessary. Linberg<sup>20</sup> has made the suggestion that muscle and fascia be closed, but not the skin, in an effort to reduce the incidence of serious infection in the parietal wound. If large defects of the thoracic wall are present, the pleural cavity may be closed by suturing the diaphragm or the lung to the opening and then packing the parietal wound. All pleural cavities should be drained with an intercostal tube with water seal, since fluid may accumulate or a broncho-pleural fistula open, which suddenly would endanger the life of the patient.

Serious thoracic wounds may be caused by bullets and shell fragments that do not require

the immediate life-saving operations demanded by severe hemorrhage and open wounds. Bullets, which can be deformed by contact, may carry into the pleural cavity and lung, rib splinters and clothing. The bullets may lodge in the chest. Shrapnell and small shell fragments cause similar wounds whether passing through or remaining in the chest. Such wounds should be operated upon as soon as possible; Sauerbruch and Küttner (Goetze<sup>12</sup>) obtained excellent results by early operation. These are the wounds treated in the second echelon of surgical hospitals during the Spanish Civil War. The wounds of entrance and exit should be excised and the chest adequately opened. Broken portions of bone should be removed and the thoracic cavity cleansed. Foreign bodies along with devitalized pulmonary tissue should be removed from the pleural cavity and the lung.

Small retained missiles may not cause serious external wounds or hemorrhage. Petit de la Villéon<sup>26</sup> has devised a method of removal with a special curved clamp, introduced through a small intercostal wound under fluoroscopic control. He operates one month after injury and under general anaesthesia, and does not believe that the slow introduction of a blunt instrument into tissue that is alive and healthy produced harmful results. He had only three deaths in 1,000 cases during the World War I. Barthélemy<sup>1</sup> performs this operation ten days after injury. Ideally, all foreign bodies should be removed, but small metallic bodies have been left without unfavorable results.

Abdomino-thoracic wounds present a most difficult problem to the war surgeon. Authors have variously advocated opening the chest or the abdomen first. Obviously the most serious presenting symptoms of injury to one cavity and its organs call for its immediate treatment, with later care of the other. In bullet wounds involving both cavities, the abdomen should be cared for first unless life-threatening thoracic hemorrhage is present. Gask,<sup>11</sup> Gordeon-Taylor,<sup>14</sup> and Roberts<sup>27</sup> advise that thoracic wounds be cared for primarily, with treatment of the abdominal injuries through the radially split diaphragm. It is apparent that nowhere

is the judgment of the surgeon more taxed than in the care of these injuries.

Closed hemothorax following injury from small missiles presents a frequently met problem. All hemothoraces should be aspirated to remove the blood, which forms an excellent culture medium for bacteria, and to prevent the late effects of spontaneous absorption; retraction of the lung, mediastinum, and thoracic wall; elevation of the diaphragm; thickening of the pleura; and diminished pulmonary function. Aspiration should begin within a few days of injury with removal of 250 to 500 cubic centimeters of blood each day. Brock<sup>2</sup> aspirates blood after the first twenty-four hours. It is preferable not to replace the aspirated blood with air, as advised by Edwards and Davies<sup>9</sup> and others. Their opinion is based on the belief that pneumothorax is beneficial, by collapsing the lung from which bleeding is occurring. Morelli<sup>25</sup> proposed and practiced pneumothorax for all degrees of pulmonary hemorrhage and his instructive book should be read by all interested. Kretzschmar<sup>19</sup> has recently advanced Morelli's views. Linberg<sup>20</sup> states in advocating early aspiration, however, that he has never seen bleeding that occurred from removal of the blood from the thorax. Certainly reexpansion of the lung, the ultimate result of successful treatment, is hastened by not introducing air.

As a usual rule the blood does not clot in the pleural cavity. At times, however, partial or complete clotting occurs. This condition must be quickly recognized, and all massive clots should be removed promptly by open operation and the thorax closed without drainage to prevent retraction of the lung and thoracic wall. Brock<sup>3</sup> states that this serious condition will not occur if blood is aspirated early.

The blood aspirated should be carefully examined for evidence of infection. Smears should be examined for organisms and cultures planted to detect aerobic and anaerobic bacteria. The established principles for treatment of empyema, so well stated by Graham and Berck,<sup>13</sup> should be followed. Whatever may be the opinion regarding air replacement of aspirated blood, no air should be introduced

into the pleural cavity in the presence of infection. Pus should be aspirated daily to decrease the size of the empyema pocket and control toxemia until the pus has become thick and drainage is safe. Livingstone<sup>21</sup> suggests that a small incision be made down to an intercostal muscle and packed open each day after aspiration; in this manner spreading infection of the thoracic wall from mixed organisms may be avoided. Although intercostal drainage has been used successfully by many surgeons, rib resection provides more adequate drainage through a large tube and an opportunity to remove clots and loose foreign bodies. Either method should be followed by adequate after-care with establishment of closed drainage systems, whose efficiency may be increased by the use of high negative suction as described by Trethewie.<sup>31</sup> Irrigations with Dakin's solution are beneficial in the after care of empyema. An exception to delaying drainage and using aspiration for a time must be made in the presence of broncho-pleural fistula, a condition calling for immediate operation; the danger of pulmonary infection from the pleura must be removed through efficient drainage.

Although the great majority of cardiac wounds are almost immediately fatal, experience of civil life has shown that some stab and bullet wounds are amenable to surgical treatment. Patients with penetrating wounds of the thorax should be examined with attention to the possibility of cardiac injury being present. The cardinal signs of compression of the heart from blood in the pericardium are increased venous pressure, low arterial pressure, and a quiet heart. At operation the compressing blood is removed from the pericardium and the wound of the heart or coronary vessel closed.

During the present war, it may be hoped that improvement in the results of treatment of thoracic wounds may be achieved through the use of sulphonamide drugs. Topical application of sulphonilamide should be the rule for all wounds of the thoracic wall whether packed open or primarily closed. It is doubtful if much is to be gained by placing sulphonilamide in a pleural cavity that is to be drained, but it may be used in lung wounds before

suturing. Oral administration of the drugs should supplement treatment of all types of thoracic injuries with the use of parenteral methods if necessary.

Inhalation anaesthesia given through an intratracheal tube with an inflatable cuff in place is the most satisfactory method for operations with an open pleural cavity. Chloroform, nitrous oxide, ether, and cyclopropane have been advised by various authors. The latter two are certainly the most suitable, and ether is the more expedient for use under war conditions. Although, according to Talbot<sup>29</sup> the French surgeons have never feared using ether anaesthesia without intubation, controlled respiration with or without positive pressure, these adjuncts should always be available to insure maximum safety. Evipal and sodium pentothal have been advanced as intravenous anaesthetic agents available, simpler and safer to administer in battle areas. They may be dangerous, however, because of the occurrence of laryngeal spasm and depressing effects on respiration.

Intratracheal intubation is of the utmost value in operating on thoracic wounds. An adequate, constant airway is assured at all times. Furthermore, blood and mucous secretions may be aspirated during the operation by a catheter introduced through the tube. Adequate ventilation maintained by normal or controlled respiration, with or without positive pressure, can be maintained, and if desirable, complete temporary apnoea can be induced during difficult and delicate procedures such as ligation of pulmonary vessels.

In the postoperative care of patients with thoracic injuries, especial care must be paid to the prevention and treatment of pulmonary atelectasis. Ryle<sup>28</sup> writes of its dangers and warns against the transportation of patients, who are allowed to lie on the uninjured side of the chest. Patients recently operated upon should not be transported unless necessary. Coughing should be urged and aided, and if it

is unsuccessful, intratracheal catheter suction as described by Haight<sup>15</sup> or bronchoscopy should be used without delay to remove blood or secretions from the bronchi. Oxygen, which is preferably given by intranasal catheter, should be available for use. Face masks are not suitable since they interfere with effective coughing.

#### SUMMARY

The increasing use of explosive missiles in modern warfare has caused a rise in the incidence and severity of thoracic wounds. Emergency treatment on the battlefield and in battalion aid stations is limited to control of superficial hemorrhage and closing open wounds with occlusive dressings. Chest wall wounds should be excised and not closed primarily. The most favorable group of thoracic wounds are those caused by bullets, which often do not require operative therapy. Severe hemorrhage and open chest wounds require immediate operation to save life. The not acutely threatening thoracic wounds may be treated with less haste. Closed hemothorax requires early aspiration and empyema treatment according to principles well established. Certain cardiac wounds may be successfully operated upon. Sulphonamide drugs should be used in all cases of thoracic wounds as indicated. Intratracheal inhalation anaesthesia is recommended.

TABLE 1

Author	War	Percentage of Wounds	
		Rifle	Explosive
Fischer <sup>10</sup>	Franco-Prussian .. (Germans)	91.6	8.4
Makins <sup>22</sup>	South African ...	95.	5.
Fischer <sup>10</sup>	Russo-Japanese ...	85.	15.
Hoff <sup>16</sup>	Russo-Japanese ...	80.	20.
Kirschner <sup>18</sup>	World War I 1914-1915 ..... (Germans)	22.3	49.29
Kirschner <sup>18</sup>	World War I 1916-1918 ..... (Germans)	6.	85.



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## ACTIVE IMMUNIZATION AGAINST TYPHUS

Although the value of typhus vaccination may not yet be definitely established, says *The Journal of the American Medical Association* in an editorial in its June 6 issue, a recent War Department order for the immunization of all military personnel who may be exposed to the disease is sound.

Discussing the present status of active immunization (created within the body in contrast to passive immunity which is introduced into the body) against typhus, *The Journal* says:

"Typhus is an invariable accompaniment of war and famine. Although accurate information on typhus in this war is not yet available, it seems to be increasing in the Balkans, Spain, Poland and the regions about the Russo-German fronts. There are rumors that the disease is spreading in Germany from infected soldiers, though the claim is made that the menace has been banished from Germany. \* \* \*

"The War Department of the United States has issued a directive to the effect that all military personnel stationed or traveling through areas in which there is danger from epidemic typhus are to be immunized with typhus fever vaccine prepared by the Cox yolk sac culture

method. The initial vaccination is to consist of three injections of 1 c.c. each, administered subcutaneously (beneath the skin) at weekly to ten-day intervals. Subsequent vaccinations of a single 1 c.c. dose are to be administered every four to six months as long as serious danger of infection is present, and other single doses may be given whenever in the opinion of the surgeon this additional stimulation of immunity is indicated.

"The value of typhus vaccination has not yet been definitely established. One of the major difficulties has been the lack of a suitable experimental animal, though the eastern cotton rat may prove to be such an animal. Adequate controlled clinical trial is also necessary, and this too is lacking. Pending acceptable information of this nature, none of the vaccines available in this country can be considered acceptable for routine mass administration. The War Department recommendations seem sound; other preventive measures involve satisfactory diets, avoidance of overcrowding and the maintenance of an adequate, trained personnel and mobile delousing equipment for use in emergencies."—*American Medical Association News*.

## URINARY TRACT PATHOLOGY ASSOCIATED WITH CARCINOMA OF THE CERVIX

By IRWIN MARKOWITZ, M.D., F.A.C.S., and J. D. KATZ, B.S., M.D.  
Jersey City, N. J.

A great deal has been written concerning carcinoma of the uterine body and cervix, yet surprisingly little attention has been given to the fate of the nearby urinary tract in these cases. The incidence of the arrest and cure of these carcinomata is definitely on the upgrade (the consensus of reports indicates a 25 per cent cure in cases of all grades, and 60 per cent in cases of Grade I). One should, therefore, be on his guard not to permit a patient to succumb meanwhile to any remediable complication.

The purpose of this brief paper is to discuss, first, the high incidence of complications in the urinary apparatus as a direct result of the disease or as an indirect complication of the treatment. Second, the importance of early recognition. Third, the necessity of prompt treatment.

Irradiation has become the treatment of choice in this condition, and is effecting more and more cures. Facilities for the use of x-ray and radium are almost universal. The secondary urologic complications from treatment may occur even in expert hands. The complications may cause marked disability which may culminate in death, *not* from the malignancy per se, but from the therapeutic measure employed. Between 60 to 70 per cent of these cases show some urologic complication, 27 per cent of these having bladder involvement. It is poor therapeutics if a woman dies, not of her primary carcinoma, but of complications directly attributable to the treatment, particularly when she might in reality have been cured of her carcinoma.

There are definite anatomical reasons for the frequent involvement of the lower segments of the ureters and bladder, both by contiguity and lymphatic interrelationship. The proximity of the ureters to the cervix can be attested to by the gynecologist who has tied off a ureter while doing a hysterectomy and found it, to say the least, rather disconcerting.

The effects of carcinoma of the cervix or irradiation on the urologic tract can be very simply classified as follows:

First, the effects on the bladder:

a. Direct extension of the tumor by malignant infiltration and invasion, which may eventually lead to a vesico-vaginal fistula.

b. Indirectly the effect may follow irradiation, where an obliterative endarteritis is produced, resulting in ischaemia and in the formation of a trophic ulcer with secondary fungating and encrusted cystitis. This change may also terminate in a vesico-vaginal fistula.

Second, the effects on the ureters and the kidneys may be produced:

a. Directly by encroachment of the tumor upon the lower segments of the ureters, producing obstruction, or the tumor may displace the ureter, producing extrinsic pressure with resulting obstruction.

b. Indirectly as a result of the treatment, producing oedema, infection and fibrosis with occlusive obstruction of the lower ureters. These obstructions in turn may produce hydro-ureters, hydronephroses which may eventually become infected. Occasionally a nephrofibrosis with calcification results, or a squamous cell carcinoma of the kidney may result from metaplasia due to chronic infection. The parenchymal damage eventually leads to uremia, this being the usual cause of death.

I should like to dwell on the indirect lesions of the bladder, those due to irradiation, in a little more detail. These cases are essentially free from malignancy and unless one recognizes the nature of this type of pathology, one is apt to attribute it to the extension of the tumor. Clinically, one cannot differentiate tumor invasion from an indirect ulcer due to irradiation. An incorrect diagnosis is made if the physician assumes that it is extension of the tumor into the bladder and does not bear in mind the possibility of irradiation injury. Radiation ulcers are usually delayed lesions,

some appearing as late as nine years, usually not before one year. Because of this frequent long interval between irradiation and the onset of symptoms, one should interrogate for a history of previous irradiation in a female complaining of bladder symptoms. This differential diagnosis is of paramount importance to the patient because the irradiation ulcer is curable and the prognosis is good. Therefore, cystoscopy and biopsy are essential in all such cases. One should be extremely careful to avoid infection of the bladder (by catheterization for example) during the period of radium therapy because it predisposes and aggravates these various pathologic conditions.

The symptoms in the cases of upper urinary tract pathology may indicate the bladder without any clinical symptoms referable to the kidneys. Others may present symptoms of loin pain, urosepsis, and acute and chronic uremia. The diagnosis is made by history, physical examination, blood chemistry, urography and cystoscopy. Cases recognized early may be managed by ureteral dilatation; whereas in the more advanced cases, one may be confronted with the more serious problem of nephrectomy, or diversion of the urinary stream by one of the following measures: nephrostomy, ureterostomy, uretero-cutaneous neostomy, uretero-intestinal anastomosis or reimplantation of the ureter into the bladder. The management of post-irradiation bladder lesions is mainly by the use of chemotherapy, cystoscopic removal of calcareous and encrusted deposits, fulguration of fibrotic ulcerations, and irrigations with weak acid solutions.

It has been shown that the vast majority, 60 to 70 per cent of cases of carcinoma of the cervix die because of urinary tract pathology, whether due directly to the carcinoma itself or indirectly to irradiation. This being the case, it becomes obvious that careful watch of the urinary tract must be constantly maintained. This is best accomplished by a urologic check-up as soon as the diagnosis of carcinoma of the cervix is established, and this procedure should be considered routine at this time. Subsequent to this, careful look-out for urologic symptoms should be made, and immediate investigation instituted on their appearance.

Early diagnosis is paramount in order to avoid the far-reaching consequences.

In summarizing: when urologic pathology has been established in a case of carcinoma of the cervix the physician must at once place the case in either of the following categories:

- a. Does the patient have a residual carcinoma?
- b. Has the carcinoma been eradicated and is the urological pathology due solely to irradiation sequelae?

The therapeutic management of a case will depend on the category in which the patient has been placed. If carcinoma is still present, the problem of therapeutics is purely one of palliation, surgery being indicated only for the relief of acute symptoms, such as urosepsis or severe loin pain. Surgery may also be considered where the outstanding clinical picture is that of a rapidly progressive obstructive uremia as in a case of a slowly advancing carcinoma. Hydronephrosis without symptoms would not warrant surgical intervention. Conservative measures, such as ureteral catheterization, would be indicated in this group.

In the group of cases in which carcinoma is eradicated, therapy becomes purely a urologic problem, treatment being directed to existing lesions whether they be bladder, ureter, or kidney. It is in this group that the recognition of the basic pathology is vital because the prognosis is good. With reference to post-irradiation vesico-vaginal fistulae, surgical attempts at repair of this type of fistula are usually unsuccessful due to fixation of tissue, dense fibrosis and ischemic tissue due to obliterative endarteritis.

In conclusion, we find, first: that justifiable palliative urologic measures may prolong the life of the patient even in cases with active carcinoma of the cervix. Second: that some individuals may be cured of their primary disease, but succumb to the effects of urologic pathology due to irradiation.

*Editor's Note:* The two illustrative cases here presented were selected from nine submitted by the author.

#### CASE 1

Mrs. B, age 56, white, was admitted to Christ Hospital August 26, 1938, complaining of hema-



turia with difficulty in voiding for past two weeks. Has never had hematuria previously. Her past history was that she had received x-ray and radium treatment for carcinoma of the cervix in October, 1928, in London. Since then she had been feeling well, with no weight loss or further vaginal bleeding. Cystoscopy revealed a bladder full of clots, which were evacuated. After evacuation, the bladder mucosa appeared edematous throughout, but on the floor adjacent to the left ureteral orifice there was an adherent white calcarious slough. Biopsies taken from this area showed inflammatory tissue. Urographic examination of upper tract showed:

1. First degree right hydronephrosis.
2. Non-functioning left kidney with calculi—  
asymptomatic.

Treatment consisted of acid irrigations of the bladder and cystoscopic removal of calcarious slough.

She was discharged from hospital with no further bleeding and symptoms relieved. Cystoscopy on January 4, 1938 (four months later) showed bladder to be clear of any lesion.

This case is one that demonstrates post-irradiate pathology where carcinoma of the cervix has been cured. A period of ten years elapsed following irradiation before bladder pathology appeared. This case also shows the amenability to treatment of this type of lesion.

## CASE 2

Mrs. McC., age 48, white, was admitted to Christ Hospital on January 10, 1938, for vaginal bleeding. Examination of cervix and biopsy revealed carcinoma of the cervix—squamous cell, grade II. Given 5000 Millecurie hours of radium. No urinary symptoms at this time. Was discharged and returned to hospital in September, 1938, and cervix was amputated (no carcinoma could be found in tissue removed). Was discharged at the end of a week, no urinary symptoms.

Two weeks after discharge developed urinary incontinence (September 28, 1938). Examination revealed a vesico-vaginal fistula. On October 16, 1938, an attempt to repair vaginally was unsuccessful. On November 19, 1938, a right uretero-sigmoidostomy was performed. Was discharged from hospital February 4, 1939.

Carried on fairly well throughout 1939, but was readmitted in January 11, 1940, with signs of uremia and a painful, tender, enlarged left kidney.

Left nephrostomy was performed on January 16, 1940, but uremia deepened and patient expired on January 19, 1940.

Post mortem showed no evidence of carcinoma. This case demonstrates the futility in attempt to repair post-irradiation vesicovaginal fistula because of dense fibrosis and ischemia. This also demonstrates a death due to urologic pathology resulting from radiation therapy where the malignancy was eradicated.

2157 Hudson Boulevard

## MEDICAL MANAGEMENT OF PYLORIC OBSTRUCTION

At the Lahey Clinic the patient with obstructive symptoms is routinely treated by inserting a Levin tube through the nose into the stomach and aspirating all of its contents. Then through the tube, 3 ounces of malted milk made with water or 3 ounces of peptonized milk is introduced every hour on the hour. The tube is clamped for 30 minutes so that no drainage from the stomach is permitted. At the end of 30 minutes, the tube is unclamped, the tip of the tube is lowered beneath the level of the patient beside the bed into a bottle and the stomach is allowed to drain by siphonage. This alternate feeding and drainage is continued throughout the 24 hours, day and night. In addition to this alternate feeding and drainage through the nasal tube, it is important to pay special attention to the fluid balance of the patient; he should be given intravenous glucose

or glucose and saline solution in fairly large quantities during the period the tube is down. He probably will also need parenteral vitamins, particularly vitamin B.

If it is learned, after watching the patient for 3 or 4 days, that the obstruction will not be relieved, and if the return drainage through the tube amounts to 20 ounces or more in 24 hours, the patient will certainly require operation; further drainage will probably not accomplish any more than the first 3 days have already accomplished. The stomach at this time will be found to be collapsed, the gastric tone will have returned, motility will be moderate and not exaggerated and the patient will be in much better condition for operation than if he had been operated upon at admission.—S. Allen Wilkinson, Surg. Clin. North America, Lahey Clinic Number, 21:735 (1941) (Clinical Abstracts).

## A CASE OF HYPOPHYSEAL DEFICIENCY RESEMBLING SIMMOND'S DISEASE

### SUCCESSFUL TREATMENT WITH PELLET IMPLANTATION OF DESOXYCORTI- COSTERONE ACETATE \*

By THOMAS P. PROUT, M.D., and CARROLL S. THOMSON, M.D., Summit, N. J.

The following case seems worthy of report because of the confusing picture brought about by the use of the x-ray as a therapeutic measure.

Miss A. F., school teacher, aged 45 years, was admitted to Fair Oaks Sanatorium November 16, 1936, complaining of weakness, inability to take food, restlessness, sleeplessness and loss of weight.

Her illness began about two years previously when she noticed that she was losing weight and sleep. She experienced periods of marked cardiac palpitation. These were aggravated at times, but she was nevertheless able to continue her work until May, 1936. She had consulted various physicians who, in spite of no manifest evidence of thyroid enlargement, made a diagnosis of hyperthyroidism. Her pulse range was from 84 to 110 and her B. M. R. was at that time +50 per cent. She was placed in a general hospital where x-ray treatments were decided upon and she received eight treatments while in the hospital. There was no manifest improvement. She was unable to return to work but tried to keep going. There were periods of vomiting and total inability to take food. There were varying periods of depression and cheerfulness, but the depression was markedly increased at the menstrual periods and aggravated by periods of palpitation. Following the x-ray treatments she steadily lost weight. During the four or five weeks previous to admittance to the sanatorium there was noted some edema of the ankle. While in the hospital, she suffered from hallucinations, which disappeared when she returned home. She did not improve while at home but on the contrary steadily lost weight. She called in her physician, who recommended that she go to the sanatorium. The physical examination showed a patient manifestly depressed, very thin, weight 90 pounds, nutrition poor, knee jerks and elbow jerks active; heart size, nor-

mal, no murmurs; pulse regular, 82; blood pressure 130/85. Teeth sound but showed many fillings, lungs no pathology, mouth and throat negative, tongue clean.

A course of iodine therapy was instituted: the patient receiving Calcidin grains V four times a day, with daily skin paintings of iodine. This was continued until December 22, 1936, though her B. M. R. had dropped to -14 per cent, and as there was no appreciable gain of weight and the pulse was becoming more rapid (at times 120), the iodine was discontinued. Parathyroid therapy was instituted in the hope of slowing the pulse rate. At first she received parathyroid gland 1/10 grain twice a day and later parathyroid by hypodermic injection was added. There was no evidence of any material improvement.

On January 26, 1937, thyroid therapy was first instituted by giving 1/10 grain doses four times a day. This was subsequently increased to 1/2 grain t.i.d. Thyroid was kept up about four months with rest periods and patient improved in weight with the B. M. R. at +40 per cent; however, during this period her ups and downs were pronounced and the B. M. R. was rising so much that it was felt that the question of an exploratory operation should be considered.

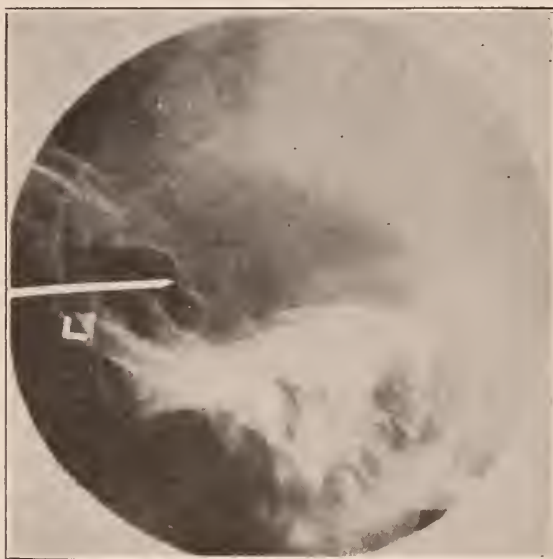
An operation was finally decided upon and all medication was discontinued, with the exception of a course of iodine therapy in the form of Lugol solution preparatory to the operation. During this treatment, the weight dropped further.

August 2, 1937, an exploratory operation was done, showing complete destruction of the thyroid and parathyroid glands. Her weight at that time was 98 pounds. Her treatment immediately following the operation was directed to restoring the thyroid and parathyroid function which was considered as mainly destroyed. Iodine (Lugol) calcium, glucocalcin,

parathyroid by mouth and by hypodermic, thyroid in large and small dosage, also quinine, insulin and the high caloric diet were made use of in this attempt.

At this time her basal metabolism was +25 per cent. Her weight dropped to 95 pounds and fluctuated around that point. During this time her R. B. C.'s varied from 4,240,000 to 4,560,000. There was slight improvement and it was thought best to try home treatment for a while and to there continue the regimen. She went home on December 20, 1937, and did not do well and so returned in May, 1938, with weight at 95 pounds. By the end of the summer, she attained a weight of 104 pounds. Her weight dropped to 91 pounds when iodine medication was resumed, her R. B. C. count being at this time 4,400,000, hemoglobin 80 per cent, W. B. C. 4,000. The conclusion drawn was that iodine medication did harm. Believing that the pituitary needed investigating, x-ray plates of skull taken on October 28, 1938, showed marked calcium deposits in a relatively small Sella Turcica. (See x-ray plate.) It was quite evident that the pituitary function must be greatly interfered with. Her weight was 86½ pounds. The R. B. C.'s were 3,760,000; hemoglobin, 70 per cent; W.B.C.'s 6,200. On December 8, 1938, desoxycorticosterone acetate was started, five milligrams being given every eight hours. Her weight rose to 94 pounds. On December 20, 1938, she had a severe vomiting attack and her weight dropped to 90 pounds. It continued to drop until December 30th when it reached 86 pounds. A blood chemistry was done at this time showing the chlorides to be 313.5 mgs./100 c.c. Sodium chloride was administered by hypodermoclysis. The weight began to rise. Her R. B. C. had risen to 4,400,000, hemoglobin between 70 and 78 per cent, W. B. C. 4,800. On February 9th the patient began to receive 0.5 mgs. doses of estradiol in the hope of regulating her menstrual periods. Her weight rose from 94 pounds to 104 pounds. On February 27th, the patient was depressed and complained of excessive nervousness. The estradiol was discontinued on the 15th of March without obtaining the desired results. She lost some weight at this

time, dropping to 96 pounds. The saline injections were resumed. On March 30th the weight reached 101 pounds. On April 10th, 1939, a milligram pellet of desoxycorticosterone acetate was implanted in her right abdomen. April 18, 1939, the urine showed a heavy trace of albumin; there were also attacks of tachycardia, an enlarged liver and spleen, and some dyspnoia. On April 25, 1939, an electrocardiogram was made which showed moderate myocardial pathology. Readjustment of the desoxy-



Sella Turcica showing bridging and calcium deposits in pituitary.

corticosterone—Sodium Chloride dosage appeared indicated and was accomplished. On May 2, 1939, 120 grains of Na Cl was administered orally, and continued indefinitely. On May 3rd the urine was normal. The weight had dropped to 94 pounds. On May 17th her B. M. R. was +44 per cent, blood count normal. On May 20th desoxycorticosterone acetate by hypodermic was given every third day intramuscularly. The weight was increasing but she still showed a slight edema of the ankles. The B. M. R. was +36 per cent. On May 23rd the desoxycorticosterone acetate by hypodermic was discontinued. Her medication at this time consisted of Na Cl, grains LX and sodium bicarbonate, grain XL, and 2,000 units of thiamine chloride daily. On June 15th her B. M. R. was +19 per cent. August 11th



anterior lobe pituitary was given five grains four times a day. On that day the patient left the sanatorium feeling better, and weighing 97 pounds. During October nasal inhalation of posterior lobe pituitary were started, also 500 units of ascorbic acid t.i.d.

She lost weight and showed a heavy trace of albumin, therefore both were stopped. It seemed evident that desoxycorticosterone acetate was our most important if not our specific line of treatment for this case. It was therefore resumed by hypodermic every second day. Her weight began to increase. On November 14th her B. M. R. was +21 per cent and her S. D. A. (specific dynamic action) was +49 per cent. On November 28th a 118 milligram pellet of desoxycorticosterone acetate was inserted under the skin of the abdomen and the hypodermics were stopped. On November 30th a second electrocardiogram was made showing a decided improvement but with still some myocardial pathology. On June 8, 1940, a daily ampoule of desoxycorticosterone acetate was resumed. The patient held her weight around 90 pounds. On January 26th another pellet of desoxycorticosterone acetate was inserted. Her weight went up to 97 pounds. She, at this time, showed some minor attacks of tetany and to meet this complication, on February 14th calcium lactate medication was instituted starting with five grains t.i.d. The patient's B. M. R. at this time was +17 per cent, and her S. D. A. was +39 per cent. On February 26th the calcium lactate was increased to ten grains t.i.d. Her weight continued to improve (98 pounds) by April 10th and the blood chemistry showed the blood calcium to be 12 mgs./100 c.c. and the phosphorus 4.4 m./100 c.c. On May 18th five units of insulin t.i.d. were given. On May 28th her blood chemistry showed: blood sugar 140 mgs./100 c.c. The insulin was increased to ten units t.i.d. On June 15th a pellet containing 127 mgs. of desoxycorticosterone acetate was inserted. She left the sanatorium on June 29th much improved and returned on September 2, 1940, for a check-up. Her weight at this time was 107 pounds. She was feeling greatly improved and was allowed to resume her school work. A daily hypodermic of  $\frac{1}{2}$  c.c. of Col-

lips parathyroid hormone was started, and the tetany attacks became less frequent, and less severe. She was able to teach throughout the 1940-41 school year. On July 1st, 1941, her weight was 106 $\frac{1}{2}$  pounds. She was taking 77 $\frac{1}{2}$  grains of calcium gluconate daily and  $\frac{1}{2}$  c.c. of Collip's parathyroid hormone. The tetany attacks were less frequent. One capsule of vitamin B complex twice a day was added to her medication. On July 8, 1941, her weight was 103 $\frac{1}{2}$  pounds, and her blood count was normal after having taught for a year. By September 9, 1941, the parathyroid hormone had been worked up to 1 c.c. daily. Her weight was 110 pounds. Her medication consisted at this time of 16 Iberin capsules daily (to raise the hemoglobin), 75 grains of sodium chloride by capsule three times a day. The last tetany attack reported was a rather severe one on September 21, 1941, with the further report that the attacks are further apart but decidedly more trying and severe than when they first began.

A blood calcium test was made which was normal. We decided to discontinue the administering of parathyroid hormone and increase the calcium gluconate to ten grams daily. The necessity for so many repeated blood calcium analyses may be avoided by testing the urine with Sulkowitch's reagent. The amount of calcium in the urine and the probable normal level of the blood can be determined by this test alone. So, by the use of this test we shall be able to keep a more rigid check on her blood calcium and by this procedure we hope to eliminate these attacks of tetany. Her blood chemistry for the past six months has been normal.

#### REMARKS

This case in the beginning was clinically what most practitioners would consider hyperthyroidism without manifest goiter or exophthalmos. The B. M. R. was high but variable and the pulse was very high at times but also variable. The symptomatology was indeterminate. The general character of the case was such that the probability is that most would sanction x-ray treatment on the assumption of an over-active thyroid gland. In the absence

of any pronounced increase in the size of the gland, and any indication of exophthalmos this proved to have been a grave error. As a result of this treatment the patient became worse and during this treatment she was hallucinatory. But, as a fact, it was hard to give up the hyperthyroidal theory until the hypophyseal condition was investigated. The result was convincing. We believe this case was sympto-

matically one of Simmond's disease from the beginning and that the x-ray treatment of the thyroid gland merely served to emphasize and further confuse the picture by so involving the parathyroid that attacks of tetany resulted. Of course, there should be routine x-ray of the hypophyseal area in any case of this kind.

Acknowledgement is made to Dr. H. H. Bowles for the pellet implantations and to Dr. J. D. Tidaback for the x-rays.

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## ACCELERATED PROGRAM OF MEDICAL SCHOOLS

Regarding the accelerated program of medical schools, the Council on Medical Education and Hospitals of the American Medical Association reports in its fortieth annual compilation of medical licensure and allied statistics, published in the May 9 issue of *The Journal of the Association*, that "As a war measure, programs have been initiated to increase the supply of physicians for the Army, Navy and civilian population by the adoption of an accelerated program of medical education by the various medical schools of the country."

Forty-nine medical schools have adopted an accelerated curriculum involving both the acceptance of entering students and the graduation of a class every nine months but will admit an entering class on an annual basis. One school will continue operating on the four quarter plan, admitting new students and graduating a class every quarter. Eight schools have not adopted an accelerated program.

"As has been pointed out," the report says, "there are many difficulties involved in the acceleration of the program, and where a school has failed to adopt such a program in order to maintain satisfactory standards it is to be commended rather than criticized.

"The acceleration of the training of medical students to the end that graduation will occur following three calendar years of instruction raises questions concerning medical licensure that demand consideration along with a consideration of the merits of the proposal itself.

"The medical practice acts of the several states define the standards that a medical school must maintain in order that graduates may qualify for licensure. If those standards are defined in such a way that course of study must be given in four different calendar years, the obvious result will be that graduates after the abbreviated course will be disqualified for licensure unless the standards are reset by amendatory legislation."

The report says that "Within the next few months an attempt will be made to develop a fairly accurate approximation of the number of trained personnel to be secured by this process of speeding the production of physicians and to ascertain whether the number of physicians so trained will be adequate to supply the anticipated needs of the military and civilian population for new graduates during the next few years."—*American Medical Association News*.

\* Supplied as per cortin by Ciba Pharmaceutical Products, Inc., Summit, N. J.

## THE ITCH TO WRITE \*

By HENRY A. DAVIDSON, M.D., Editor of *The Journal* of The Medical Society of New Jersey

The only labor pains which the average doctor can ever really experience are the pangs of authorship. Your Medical Society is no believer in birth-control in the field of ideas and encourages members who have something to say to offer their intellectual progeny to the *Journal*. Reasons that move the author to write are varied. A sincere desire to make a contribution to medical lore; a feeling that some observations might be of interest or help to fellow-practitioners; and, in some cases, vanity. Even the latter motive is not ignoble if the fruit of the vanity is a communication which helps shape another doctor's ideas on some scientific topic. Editors do not weigh your motives. They are interested in only one thing: is this paper helpful to the practitioner?

### NOVELTY

A State Journal cannot insist on only brand-new, totally fresh ideas. After all, there are very few absolutely original scientific discoveries in a century. On the other hand, no editor welcomes a manuscript which reflects only the diligence with which the writer has copied text-books. This *Journal* does not consider a paper satisfactory if it merely represents the reading and notetaking of some staff-member who was coaxed into reading a paper at a hospital meeting. What usually happens is that the doctor is first unwilling, then reluctantly takes to his books and works out a readable paper; then, he looks it over, says to himself "This looks pretty good," and sends it to the *Journal*. But our *Journal* is not a readers' digest. The medical reader will do his own digesting.

On the other hand, a paper of this sort might be acceptable if the material is filtered through the author's own experience; if he can critically review the texts he has read, and point out how standard observations have been

modified in his experience; and if he can add a few illustrative cases of his own. For instance, an article on the treatment of ainhum is not acceptable if it is made up only of summaries of the text-book descriptions. But if the writer says that text-books advocate amputating at the second joint, and in his experience, amputation at the first joint was better, then the paper really makes a definite if minute contribution to the therapeutic equipment of his colleagues.

### SOURCE MATERIAL

Many a doctor looks gloomily at a spectacular case report and sighs: "Why don't I get interesting cases like that?" He does. He forgets them or he is asleep at the switch and misses the interesting features of the report. One cure for this is to keep a little note book in which you jot down odd observations as you go along. You give a patient some viburnum; he develops diplopia, and you are disturbed by it, not knowing whether that is a complication of the disease or a complication of the treatment. Suddenly the diplopia vanishes. The patient feels a little better and you feel a lot better. Enter that in your little book, and perhaps you may find that diplopia was an untoward effect of the drug. Thumb through *Index Medicus*. It was never reported before. Write about it for your state *Journal*, and you will have earned a permanent if modest niche in the hall of medicine's immortals. A decade hence, someone else will write and say, "Since 1942 when Jones first described diplopia as a complication of viburnum therapy, numerous cases have been reported."

Another good trick is to keep a diagnosis file. In your note-book, write on the top of one page "nephritis" and on the top of another "pneumonia", etc. Or use file cards, if you prefer. Enter every patient's name under the diagnosis and list complications, treatment, results and miscellaneous observations. In a

\* Read by invitation to the Warren County Medical Society, January 20, 1942.



short time you will have something worth reviewing. Do children with tonsils suffer colds more often than children who have had the benefit of tonsillectomy? Who knows? Your diagnosis file will tell what your experiences have been and an honest short paper reporting this simple observation will be a boon to medicine though it may be a boomerang to nose-and-throat men.

#### MECHANICS OF WRITING

Use 8½ x 11 paper. Many doctors write their office letters on 5 x 8 sheets, but a manuscript on that size paper is a contributing factor to the high death rate among editors. We estimate space by counting the letter-size sheets, but we need a slide rule if you use legal size paper or if you use 5 x 8 pages.

Submit the original; keep the carbon copy. If you must have the original yourself, let someone type another copy. A carbon becomes blurred, and by the time it has passed through the tender hands of an editor, editorial secretary, linotyper, compositor and proofreader, the copy has been smudged to the point of a total black-out.

Double-space your manuscripts. The editor must make corrections. Not that he wants to tamper with your English; but he must insert instructions to the printer about type-size, headings, italics, etc. On a single-spaced manuscript, he is obliged to write those instructions in the margin with long arrows to mark the spot: a procedure that encourages error and confusion.

After the manuscript has been completed, double-spaced on letter-size paper of course, mail it to the editorial office. Do not roll it like a diploma. If less than four pages, fold it twice to fit into an ordinary long envelope. If it is five, six, or seven pages, fold it once and insert it in a 5 x 8 envelope. If it is more than eight pages long, mail it flat in a large 10 x 12 envelope. Send an accompanying letter: a brief one in which you merely state that it is offered for publication. If the paper was read at a staff or society meeting, state that in a sentence immediately below the title and your name. For instance, the first three lines of the manuscript would read "MODERN TREATMENT

FOR DANDRUFF. By John Smith, M.D., Mastville, N. J. Read before the Clinical Staff of the Mastville Memorial Hospital, Jan. 2, 1942."

Do not use a special title page. Some authors start with a sheet bearing the title, name, and place read, and then begin the article on page 2. When you do that, the editorial secretary has to retype all that information on top of the first manuscript page anyway.

#### ILLUSTRATIONS

It costs from \$3 to \$8 to make a cut about 3 inches square. Many journals, including this one, ask the author to pay for this, and of course, the cut becomes his property, so that he can use it for making lantern slides or for subsequent papers. When you receive the proof of the cut, be sure to mark "top" on the upper edge. With photographs of tissues, crystals and apparatus, it is not always clear to the printer which is top and which is bottom.

#### STYLE

Any adequate review of style is impossible in a brief communication. A few highlights must be mentioned, however. The prime rule of style is to avoid sounding as if you were straining for style. I have seen a fracture referred to "a solution in continuity of a bone", and heard "bad weather" called "adverse climatic conditions". And one must distinguish between scientifically accurate language and utterly pretentious language. It is accurate to refer to table salt as "sodium chlorid", because doctors know that the word "salt" is too general. But it is pretentious to call "measles" by the Latin word "morbilli". On the other hand, avoid slang. A recent manuscript contained the sentence: "Three days post-op he could navigate about the room without help." Another author writes: "The patient received a shot of arsphenamin because he had a positive serology." Of course "getting a shot" is slang and "positive serology" is jargon. The patient received arsphenamin because he had syphilis, or perhaps, because he had a positive Wassermann.

#### THE CASE REPORT

Most of our knowledge of disease and of the effects of treatment has come out of an

accumulation of case reports. The case-report is a good form for a medical paper, provided it is used to point up some conclusion.

In a case history, avoid abbreviations. In one hospital, "wdwnwm" may mean "well developed, well nourished, white male" but in another it may mean nothing. And "the wbc was 7500 of which 75% were polys" is comprehensible enough, but is sloppy writing. To say that the blood count showed 7500 leukocytes, of which 75 per cent were polymorphonuclears takes a bit longer to write, but is at least neat, accurate, and unmistakable. Editors are disturbed by case histories that look like telegrams. "Father living and well, mother died cancer, came in complaining of pain in chest, no râles, heart negative, x-ray suspicious, and usual childhood illnesses." That kind of case reporting sounds dyspneic and it belongs in a catalogue, not in a scientific paper. The sentences in a case report can be brief without being mutilated.

#### BIBLIOGRAPHY AND REFERENCES

Many writers like to cite a long and formidable list of references. It is expected to conjure the picture of an author staying up all night in a medical library eagerly poring over *Index Medicus*. It is supposed to impress the reader: it doesn't: it frightens him. In a specialist's journal it may be proper to prepare a complete bibliography of the subject. In a general practitioner's journal, any effort to exhaust the literature will only succeed in exhausting the reader. Cite enough references to avoid the charge of plagiarism and to give credit where it is due. No more. If you are quoting from another author, naturally, give the reference. If you are saying something that

everybody knows, it is not necessary to cite authority. For instance, if you write "Hemoptysis often occurs in tuberculosis", there is no point in writing, 1, 2, and 3 after that statement, and referring us to Osler, Cecil, and Piersol, because no medical reader needs to be convinced of that. He knows it. But if you say "benzedrin has been helpful in treating paralysis agitans", you should key it to an authoritative work to give credit to the investigator who first reported it.

In giving a bibliography, cite the full name of the Journal and the page number as well as the month and year. And give the author's first name too. Editors often receive footnotes like: "Smith, J. A. M. A., 1932." That means he had to send to the Library of an Academy of Medicine to find Dr. Smith's first name, and the volume, page number and month. Do not abbreviate journal names. The editorial office will do that for you. We all may know what J. A. M. A. means, but we do not know what "A. J. P." means. Avoid Roman numerals. Can you figure out what volume xixviii means without pencil and paper? Most of us are just as illiterate when it comes to translating roman numerals mentally.

#### THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Adherence to these suggestions will make it easier for your Editorial Office to function smoothly. This *Journal* is your own periodical. It is naturally more hospitable to the work of New Jersey physicians than any other publication in the country. The *Journal* is the medium through which you can exchange ideas with your colleagues. You enjoy hearing from them. Let them enjoy hearing from you.

31 Lincoln Park, Newark, N. J.

#### "IT CAN BE GALLANT AGAIN"

"If I must face my friends in democracy trying to explain my reasons for seeking dubious safety and leaving them to their fate, I prefer the uncertainties of the hazardous undertaking, frankly faced as hazardous, and to accept them. It is my opinion that if disaster should overtake us . . . it would be no more terrible than what will happen to us if we are to try to isolate ourselves.

"We shall still have ourselves to live with. This nation has been gallant in the past, and it can be gallant again. I do not believe that there is a safe course. In dangerous times such as these . . . it is my conviction that a dangerous course has real advantages."—Frank Lahey, M.D., in inaugural address as President of the A. M. A.

## BILIARY DYSKINESIA \*

By A. J. BARBANO, M.D., New Brunswick, N. J.

Since one-half of all people past the age of 40 have some disturbance of the biliary tract<sup>1</sup> and 75 per cent of gall-bladder cases are non-surgical, it is obviously important for the general practitioner to be familiar with diseases of the biliary system. It is careless medicine to say casually that cholecystectomy is the routine treatment of chronic cholecystic disease.

Gall-bladder disease is no more a clinical entity than rheumatism or Bright's disease. Cholecystectomy is not a panacea for pain in the right upper quadrant. Too often after operation the patient returns with the same signs and symptoms. This recurrence was dubbed "post cholecystectomy syndrome", later to be recognized as *biliary dyskinesia*, or functional biliary disease. McGowen and Henderson<sup>2</sup> offered "A Means of Prevention and Management for Pain Following Cholecystectomy", and suggested a diagnostic test. It remained for Walters and Snell<sup>3</sup> of the Mayo Clinic, and Carter, Greene, and Twiss<sup>4</sup> of the New York Postgraduate Hospital to classify gall-bladder disease and select their surgical cases carefully. They advocate prolonged medical supervision, regardless of the necessity of surgical intervention for all patients with chronic disease of the gall-bladder. Biliary dyskinesia, or functional disease of the gall-bladder,<sup>5</sup> is either a spasm of the choledochoduodenal mechanism or biliary colic, or both. It is as characteristically a medical problem as cholecystitis with lithiasis is surgical. We will concern ourselves with the former.

### TYPES

Biliary dyskinesia takes three forms:

1. Reflex hypertonic type, presenting periodic attacks of colic and indigestion.

2. Hypertonic, hyperacidic type with usual periodic attacks of colic and indigestion.

3. Hypotonic, hypochlorhydric type presenting distress in the right upper quadrant with indigestion but no attacks of colic or jaundice.

For all three types, the pathogenesis is found in biliary stasis. This gives rise to the appellation "Stasis Gall-Bladder", which may be defined as an anatomically normal or nearly normal organ which by perversion of physiologic activity is capable of simulating other types of cholecystitis. The mechanism includes abnormal tonicity of the sphincter of Oddi or reflex stimulation of the gall-bladder itself.

### REFLEX HYPERTONIC TYPE

Patients of the hypertonic reflex type have normal gastric acidity. Symptoms include periodic attacks of colic, nervousness, indigestion and symptom-free intervals.

Cholecystograms indicate an enlarged hypertonic pear-shaped gall-bladder with normal response to magnesium sulfate and biliary stasis.

The mechanism is a common duct sphincter spasm caused by over-stimulation of the central nervous system or abdominal disease (in the appendix, colon, kidney, etc.).

The treatment includes removal of the exciting cause or removal of the patient from the environment; sedation, antispasmodics, bland diet, and saline catharsis.

### HYPERACIDIC HYPERTONIC TYPE

Patients with hypertonic biliary tracts differ constitutionally from those with hypotonic gall-bladders. The former are typically of the ulcer type.

Essentially symptoms are: Periodic attacks of colic, indigestion, and heart burn, or pylorospasm.

X-ray reveals an enlarged tubular hypertonic gall-bladder shadow and delayed emptying.

Gastro-intestinal examination shows evidence of duodenitis.

\* Read before the Walter Reed General Hospital Staff Meeting, Washington, D. C., February 10, 1942.

1. Rehfuess, Martin E., and Nelson, Guy M.: Medical Treatment of Gall-Bladder Disease.

2. McGowen, J. M., and Henderson, F. F.: Prevention and Management of Pain Following Cholecystectomy. New England J. Med., 222:948-953, June 6, '40.

3. Walters, Waltman, and Snell, Albert M.: Diseases of the Gall Bladder and Bile Ducts.

4. Carter, R. F., and Greene, Carl H., and Twiss, John R.: Diagnosis and Management of Diseases of the Biliary Tract.

5. Ivy, A. C., and Sandblom, P.: Biliary Dyskinesia. Ann. Int. Med., 8:115-122, August, '34.



Biliary drainage reveals gastric hyperacidity, duodenal instability, and pylorospasm.

Treatment includes: Bland diet, alkalis, antispasmodics, sedatives, olive oil, and duodenal drainage.

#### HYPOTONIC TYPE

In the hypotonic type are included most of the patients of the "fair, fat and forty" group. Females predominate three to one and a history of repeated pregnancies is usual. Obesity and low basal metabolic rates are common.

Symptoms are essentially: Right upper quadrant distress and indigestion without jaundice or colic. These are the result of atony and dilation of the gall-bladder, hypochlorhydria and deficient emptying response. The sphincter of Oddi has normal tone.

Cholecystograms may show a dilated atonic organ visualized and concentrating normally, and impaired emptying following a fatty meal.

Duodenal drainage reveals gastric hypochlorhydria and concentrated bile obtained only after stimulation with olive oil.

Treatment includes: Dilute hydrochloric acid with meals, high cholesterol and fat diet, olive oil before meals and at bed time, attention to general hygiene, tonics and duodenal drainage.

#### DRAINAGE

Duodenal drainage is an important adjunct to our clinical armamentarium. It is a two-edged sword; on the one hand it is a diagnostic aid, and on the other a therapeutic weapon. Skepticism about this procedure arises particularly from the uninitiated or inexperienced. In the hands of the novice, the maneuver teaches nothing and produces discouraging results. Ever since the promulgation of the hypothesis of Meltzer concerning the contrary innervation of the gall-bladder and sphincter of Oddi, many workers, including Rehfuss, Nelson, Cole, and Westphal, have added immeasurably to our clinical acumen by use of the Meltzer-Lyon test. It is primarily physiologic in contradistinction to the purely anatomic findings of the roentgenogram.

Briefly and with intentional omission of introductory technique, it may be said, the first step is obtaining a specimen of gastric contents. The elimination of this primary requisite would be as negligent as doing a white cell count without a differential. Then after passage of the tube into the duodenum, the color sequence of material is noted. Without fractionating the test is diagnostically useless. A response is never normal unless the thin golden brown "A" bile gives way to the thick "B" bile and finally to lemon yellow "C" bile. Studies of the fraction should include: Physical properties, quantity, smear and culture, and microscopy. The microscopic presence of cholesterol and calcium bilirubinate crystals is 90 per cent diagnostic of calculi.<sup>3</sup>

With the use of 33 per cent magnesium sulfate and olive oil, knowledge of the function of the biliary tract may be obtained. Concentrated bile, obtained only after stimulation with olive oil, indicates the hypotonic, hypochlorhydric gall-bladder. Normal response to olive oil connotes the hypertonic, hyperacidic type, whereas normal response to magnesium sulfate is typical of the hypertonic reflex type. Lack of "B" bile indicates a blockage of the cystic duct by stone, or a gall-bladder so damaged it can neither concentrate nor contract.

Diminution in quantity of "B" bile indicates partial obstruction of the cystic duct by stone. Excess "B" bile is an indication of biliary stasis and that complete evacuation can occur only as a result of intense stimulation.

#### SUMMARY

1. Biliary dyskinesia is a clinical entity.
2. Gall-bladder cases must be carefully evaluated before subjecting the patients to surgery.
3. The types of functional cholecystic disease are discussed and their signs, symptoms and treatment presented.
4. Biliary drainage is discussed as a diagnostic and therapeutic aid.

## RECOVERY FROM CEREBELLAR ABSCESS OF OTOGENIC ORIGIN \*

### REPORT OF A CASE

By ALBERT F. MORICONI, M.D., Trenton, N. J.

Recovery from cerebellar abscess is somewhat rare, hence this case report.

B. A., aged 15, had intermittent suppurative otitis media of the left ear for over two years. I first saw him on July 12, 1939, and obtained a history of weakness and drowsiness of two days' duration following an apparent acute attack of otitis media. Three weeks earlier the patient had noticed a discharge of sero-pus in his left ear. This was not accompanied by fever or pain.

This young adult male was somewhat undernourished. There was tenderness over the occipital region. Pupils were dilated, reacted to light and accommodation. Spontaneous nystagmus was noted on looking to the left, vertical nystagmus on looking downward.

Right ear: A scar was observed, evidence of a previous mastoidectomy. (He was operated upon eight years before.)

Left ear: Creamy yellow pus was removed from ear canal. The tympanic membrane had a perforation in its posterior, superior angle. Presence of granulation tissue gave one the suspicion of an old chronic running ear. No destruction of the ossicles was apparent. No tenderness was found over the mastoid area.

Nose and mouth were normal. Some muscular weakness was apparent on the right side of face and some neck stiffness on flexion of the head. Heart and chest and abdomen were normal. Some weakness on flexion at the hips and knees was observed. Knee jerks appeared normal, and pelvic girdle movement was poor, with falling to the left.

Dr. Bernard A. Hirschfield (Neurologist) was called in consultation for a neurologic examination on July 13, 1939. He found the patient was stuporous but easily aroused. The positive neurologic features were: Definite left-sided cerebellar signs such as — asynergia, adiadosokinesia, rebound phenomenon, etc., right central facial weakness, nuchal rigidity

and early papilledema on left—beginning on right. Impression: Left cerebellar lobe abscess with beginning compression of the medulla.

Dr. Seely's (Ophthalmologist) report was identical with neurologist's concerning the appearance of the optic discs.

X-ray was not conclusive. Blood count: Hg. 85 per cent, RBC 4,400,000. WBC 14,500, Poly 84 per cent, Lym 16 per cent. Urine: Sp. G. 1.020, alk., no alb. or sugar, some WBC and bact.

On the basis of the history, the physical findings, the reports of the consultants, a tentative diagnosis of cerebellar abscess of otogenic origin was made. Because of the desperate condition of the patient, an immediate mastoidectomy and craniotomy was decided upon. Dr. Benjamin H. Shuster of Philadelphia and Dr. Samuel Sica assisted.

A posterior auricular incision was made, periosteum elevated, cortex removed with gouge and antrum entered. Epitympanic dura exposed (this gave a perfectly normal appearance). The lateral sinus was exposed for a length of one and three-quarter inches and while attempting to expose its posterior border, it was accidentally entered. Posterior cranial fossa entered exposing the cerebellar dura which was grayish in color and under considerable tension.

The dura was slit and a protrusion of cerebellar cortex occurred. A small curved hemostat was plunged for a distance of one and one-quarter inches into the substance of the cerebellum. This was followed by a gush of creamy yellow pus and some blood. Culture was taken and small tube drain inserted, using the hemostat as a guide. The entire wound was packed with iodoform-gauze, left open and a dressing applied.

*Post-operative diagnosis:* Chronic mastoiditis and left cerebellar abscess.

*Time of operation:* One hour and fifteen minutes.

The immediate post-operative treatment consisted of the administration of neoprontosil 2.5 per cent, 20 cc. every four hours, intramuscularly, 50 cc. transfusions every eight hours, 1,000 cc. of 10 per cent glucose. These measures were discontinued the next day and prontosil was given orally to the

\* Read before Philadelphia Laryngologic Society, March 1941, and Otolaryngologic Section, American College of Surgeons, November 1939.

extent of 10 grains three times a day. Subsequent blood counts were made and sulfanilamid blood contents were estimated. Culture of pus from cerebellum was sterile.

His post-operative course was non-eventful. His temperature returned to normal within seven days, and remained practically normal for the subsequent sixty days. Tube and gauze were gradually removed, the tube remaining in situ for seven weeks.

On September 11, 1939, the tube was completely removed and there was a slight rise in temperature for that day which returned to normal by the next morning.

I have seen him at my office since. His post-auricular wound is now completely healed, all symptoms have disappeared, though he still had a slight aural discharge for six months.

It is now thirty months since date of operation. The adiadokokenesia, spontaneous nystagmus, aural discharge have disappeared. His Romberg is negative and no symptoms referable to his cerebellar abscess and otitis are now present.

438 Hamilton Avenue

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### LOCAL TREATMENT OF BURNS

Two new methods of treatment of burns have been found to possess advantage over older methods. For superficial burns of the face or limbs the use of sulphanilamid and tulle gras has been especially successful. In some cases, however, infection, usually with staphylococci, has supervened, necessitating a change of antiseptic. This treatment is almost painless, and need only be carried out every few days. It is the most practical and efficient method for routine use in superficial burns of moderate extent. The irrigation envelope is useful for more extensive burns, and for deep burns in which separation of necrotic tissue must take place before grafting is possible. The burnt area can be readily inspected, and free and painless movement of limbs, fingers, etc., can be carried out during irrigation. The

treatment is not always painless, and infection is controlled less well than with sulphanilamid. The application of the adhesive seal around the limb may increase the oedema of the burnt parts unless great care is taken. In some cases a change from one method to the other has been used with success. The irrigation envelope offers an alternative treatment of value in special cases. Both methods possess advantages over tan treatments: first, infection can always be limited and never develops to the same extent as often happens under an area of tan; secondly, the splinting effect of tan, with its harmful effects on the immobilized joints, is avoided. Nevertheless, in widespread burns of the trunk tanning methods may save life in the early stages.—R. S. Pearson and R. B. Niven, *B. M. Journ.*, 1941. (Clinical Abstracts.)

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### A LESSON FROM A DEATH CERTIFICATE

#### NUMBER FORTY-TWO

Gravida 4, para 3. Entered hospital with hypertension, tachycardia, and dyspnoea. Cesarean was done and macerated foetus with hydramnios found.

Patient was given a blood transfusion while on the table using the husband as donor. The patient developed anuria and jaundice. She was given five transfusions in all and soon afterward became moribund and died on the ninth day.

The history showed that all three previous pregnancies had ended with the birth of babies who died shortly after birth.

Was not this a case of a difference in the Rh factor of husband and wife so that the husband was a poor donor? This is a real danger in these cases.

A. W. BINGHAM, M.D.



## THE TREATMENT OF RECURRENT AND THREATENED ABORTION \*

MATERNAL WELFARE ARTICLE NUMBER SEVENTY-ONE

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

Abortions are interruptions of pregnancy before viability. They are designated as "threatened" when there are uterine pains or hemorrhage, and "recurrent" when they spontaneously re-occur one or more times.

Treatment cannot be standardized because there are many causes. Moreover, abortions from the same cause are treated differently by different doctors. How shall we evaluate these various treatments? There are three methods: statistical, experimental and clinical.

*Statistics* on abortions are generally untrustworthy. Mathematically based deductions are accurate only if the cases studied are comparable. Recurrent abortions comprise a confused heterogeny. Moreover, women do not always tell the truth. Histories of ward patients who have had abortions are notoriously unreliable. Private patients are probably more truthful, at least, about recurrent abortions because they do engage professional services in order to prevent the repetition of the experiences which they themselves regard as unfortunate or even catastrophic. But no one doctor has enough such private patients to warrant dogmatic conclusions.

From available *statistics*, it appears that about 240,000 spontaneous abortions occur annually in the United States.<sup>1</sup> Of these, from 0.48 per cent<sup>2</sup> to 1 per cent<sup>3</sup> are recurrent. After two successive abortions the third pregnancy has a 50-50 chance of terminating in the birth of a healthy baby regardless of treatment; after three sequential failures, these chances drop to 20 per cent, and they fall to 10 per cent after the fourth.<sup>3</sup> It is important, therefore, to consider the number of recurrences experienced when comparing one method of treatment with another. Finally, there is a small but definite group of women who recover from habitual abortion without any treatment whatever.

What have *animal experiments* taught? During the past twenty years the pathology, endocrinopathy and vitaminology of recurrent abortions have been investigated in many laboratories. So much has been written that we are about to drown in printer's ink, and all is not yet clear. Visibility still is low, but through the blur two crystal-clear facts have emerged.

1. Unpremeditated abortions are due to pathology, endogenous in the mother, or in the fertilized ovum, and not to exogenous environmental accidents which are blamed by women friends in their panel discussions around the bridge table.

2. Endocrinologists and biochemists have made brilliant contributions to the treatment of habitual abortion, i. e., progesterone and vitamin E; but their brilliance has blinded us to older yet effective measures. For example, in 1940, two women wanted to bear children. Both gave distressing histories of sequential abortions. Both had spent large sums of money, one for progesterone, the other for wheat germ oil, but each had another miscarriage notwithstanding. Subsequently the first patient conceived on New Year's Eve. Her retroflexed uterus was elevated and held in place with a Hodge pessary until after the third month. This had not been done in previous pregnancies. She is now so happy that she is going to follow an old Chinese custom and celebrate the date of the conception of her son rather than his birthday. The second patient was twenty-six pounds overweight. Although her basal metabolic rate was only plus three, she is now being given thyroid extract daily throughout pregnancy for the duration. Without either progesterone or vitamin E, she is already eight and a half months pregnant. These two women might have recovered from habitual abortion no matter what treatment was used, or even with no treatment at all. But in the experience of every veteran obstetrician,

\* Read before the Section on Obstetrics and Gynecology of the Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 22, 1942.

duplication of these experiences is seen over and over again.

In 1910 when I treated my first case of recurrent abortion, there were no Wassermanns and no B. M. R. determinations available. Nothing was known of hormones or of deficiency diets. Uterine displacements were routinely corrected. Fat women were given thyroid, and fat and thin patients alike received iodides or mixed treatment as a precaution.

Since then, great strides have been made in the endocrinopathy of abortion. Biological laboratories have poured out lavish contributions, some of which seem to have become established. Seven of these have direct bearing on treatment.

1. Corpus luteum is responsible for those proliferative endometrial changes and for the inhibition of rhythmic uterine movements which favor gestation and protect it.

2. Corpus luteum is the natural antagonist of estrin which stimulates these contractions,<sup>8,9</sup> and nullifies the posterior pituitary response.<sup>11</sup>

3. Through its influence on the epithelium of the Fallopian tube, corpus luteum preserves the viability of the ovum during nidation.<sup>10</sup>

4. Corpus luteum is essential for the maintenance of gestation until the placenta with its chorionic hormone takes over this function. This shift begins at the end of the second month, when abortions occur most frequently, but the corpus luteum of pregnancy does not entirely disappear until along about the seventh month.<sup>3</sup>

5. The physiologic action of corpus luteum is due to progesterone, which is prepared for clinical use, from pigs' ovaries or is synthesized from stigmasterol. It is eliminated in the urine as pregnandiol.<sup>14</sup>

6. We do not know what the blood level of progesterone should be or how to measure it. The complicated determination of pregnandiol in the urine may be a step in that direction.<sup>14</sup>

7. Substitution therapy with progesterone amply replaces the surgical loss of the corpus luteum of pregnancy.<sup>13</sup>

Biochemists have given us vitamins. Twenty years ago Evans<sup>21</sup> discovered an antisterility factor "X" which later became known as vita-

min E. Its active principle, alpha-tocopherol, was synthesized four years ago.<sup>22</sup> Taussig<sup>24</sup> believes that dietetic deficiencies cause few abortions in this country; others believe that "E" shortage is all too common.<sup>23, 25, 26</sup>

Vitamin E maintains the leutenizing function of the pituitary<sup>23</sup> and is indispensable to cells undergoing rapid proliferation and differentiation.<sup>25, 26</sup> Normal placental villi are supplied with trypsin,<sup>4</sup> which digests the endometrium and permits the villi to penetrate the uterine wall to a sufficient depth to insure a durable attachment. Estrin inhibits the trypsin without which the attachment remains loose. Hyperestrinism, therefore, encourages abortion. Now hyperestrinism is a constant feature of vitamin E deficiency,<sup>1</sup> which is seasonal and is particularly prevalent from January to June. The administration of vitamin E, therefore, not only aids in preventing habitual abortions but, according to Shute,<sup>4</sup> it also aids in the prevention of congenital deformities by promoting firm, durable placental attachment.

The third method of study of recurrent abortions is *clinical*. While clinical experiences lack control precision, and may suggest malodorous testimonials, yet I was asked to recount personal observations. I have followed instructions, not to prove points, but to illustrate them. Two cases have already been cited.

What else has clinical experience taught? It has taught that it is a great mistake to prescribe expensive hormones and vitamins before taking a complete history and making a thorough physical examination of the patient.

If the history reveals that previous abortions occurred early in pregnancy, the cause is apt to be pelvic; if the abortion occurred late, extra-pelvic; and if they recurred closer and closer to full term, syphilis is the probable cause.

It is said that lead, alcohol, tobacco and carbon monoxide may cause recurrent abortions. I have never seen a case of this sort. The history may reveal excessive frequency of coitus. Pelvic congestion and hyperestrinism due to frequent bursting of graafian follicles, together with the absorption of dead spermatazoa, supposedly ovacidal, may cause repeated abortions.

Physical examination may reveal a *local*

cause. When one of my internes was a fetus in utero, I removed by fulguration a polyp from his mother's cervix. She had had two previous consecutive abortions.

Twelve years ago, I kept a patient in bed for months trying in vain to prevent her fourth successive miscarriage. Had I but known, she might have been spared this effort, for she had already undergone a high Sturmdorf amputation of the cervix. Nothing on earth could have prevented *her* habitual abortions except contraception.

Fibroids may cause repeated abortions. Many years ago I assisted in an extensive jag-saw myomectomy. The patient had experienced five miscarriages in a row. After her myomectomy she became pregnant and came to term. Although the uterus ruptured, she and the baby survived.

Infantile uterus, unicameral or bifid are said to cause repeated abortions. It might be possible to develop an infantile uterus with estrin therapy before planning pregnancy.

In 1938 I cauterized a cervix chronically infected. The single previous pregnancy had ended in failure. The patient later became pregnant and went to term. She might have done so without cauterization, but cervicitis is considered as one of the causes of habitual abortion.

In 1931 the wife of an attorney was three months pregnant. She had a history of two previous abortions at the third month. I kept her in bed for two weeks and then removed a papillary ovarian cyst. No corpus luteum was present in the other ovary but she went to term.

Finally, among pelvic causes of abortion is retroflexion of the uterus with incarceration in the hollow of the sacrum. Reference has already been made to a case in point.

There are a number of systemic causes of habitual abortion. Twenty years ago syphilis caused 20-30 per cent of them. During the past ten years I have had only two private obstetric cases with positive Wassermanns. Both of these patients gave birth to healthy children.

My own experience leads me to believe that thyroid extract is the most valuable single

agent to raise the threshold of abortion. It has proven useful even where the B. M. R. does not seem to warrant its use. The exact physiological action involved is not known. It may fortify the placenta by increasing blood cholesterol<sup>31</sup> or by diminishing the estrogenic anti-proteolytic factor which prevents firm placenta attachment<sup>4</sup> or by stimulating the pituitary to produce progesterone.<sup>8</sup>

My own experience seems to justify the common sense admonition to avoid pregnancy after recurrent abortion until a normal metabolism has been well reestablished.

A few cases of recurrent abortion due to B. abortis in women have been reported, but the infection in cows leads to sterility, and a woman has never been known to transfer this tendency to another.

Diabetes was an exceedingly rare cause of recurrent abortions. In pre-insulin days genital atrophy, amenorrhea and sterility were common, but fertility has increased with the use of insulin. The control of the glycosuria is said to prevent abortions.

Abortions recur frequently in a large group of women who have acute and chronic nephritis, essential hypertension and hypertensive vascular disease; with or without eclampsia. Most of these cases need contraception rather than ill-advised attempts to preserve pregnancy.

One of the most frequent causes of recurrent abortion is hyperestrinism. Old textbooks listed endometritis as a cause of abortion, but what was then termed endometritis is now known as hyperplasia, which results from hyperestrinism. The diagnosis of hyperestrinism may be suspected if no local or systemic cause of recurrent abortion is found. The suspicion is further strengthened if stained vaginal smears (Papanicolaou) show excessive cornification of unusually large squamous cells with small pyknotic nuclei. The administration of progesterone is justifiable even if the blood estrin level is not determined; but Hamblen<sup>16</sup> warns against large doses, which may depress the metabolism of progestin. He also states that progesterone may interfere with the efficacy of thyroid extract if the abortions are due to hypothyroidism. The dose usually prescribed



is two international units a week, from the sixth to the eighteenth week. (One unit is equivalent to one mgm. or one Corner-Allen rabbit unit.) Dr. Falls<sup>18</sup> estimates the cost at \$150.00, but he continues treatment to the thirty-fourth week, which seems unnecessary. My personal experience with progesterone has been limited to five women, all of whom received wheat germ oil in addition. All went to term and there were no congenital abnormalities.

It is in this group of habitual aborters due to hyperestrinism that vitamin E is useful. The exact dose has not been established. It is given in perles or in liquid form, but it must be refined because crude oil extracted with ether is sarcogenic at least in rats.<sup>27</sup> In five cases I prescribed perles which contained 0.2 c.c. three times a day, from the first prenatal visit until the patients felt foetal movements. None of the five cases had any local or systemic cause of recurrent abortion.

Good results have been reported from the use of A. P. L. hormones.<sup>19,20</sup> The pituitary stimulates the ovary to produce esterin and progesterone. I never have used A. P. L. in recurrent abortions because I could not foretell whether it would stimulate estrin and cause abortion, or produce progesterone to prevent it.

The treatment of threatened abortion is rest in bed. Vaginal examinations, physics, visitors and other disturbers of the peace are forbidden. In the old days, morphine was administered, but data from the laboratories<sup>6,7</sup> have shown that morphine not only fails to inhibit

uterine contractions, but actually stimulates them. Sedation is needed, but barbiturates have replaced opiates. Modern treatment adds six or eight units of progesterone, which acts quickly and is reinforced by wheat germ oil, in a single massive dose of 6 drams, followed by the usual small daily dose, and weekly injections of the progesterone. The uterus should be emptied at once if hemorrhage is threatening. Slight bleeding or spotting continued for several weeks may mean a mole or a missed abortion. Repeated vaginal examinations, blood counts and Friedman tests may have to be made. If moderate bleeding, never actually menacing, continues for two weeks, the patient should be permitted to be up and about. While every attempt should be made to save a live fetus, the general tendency is to procrastinate too long.

The wisdom of arresting any threatened abortion has been questioned.<sup>28</sup> Blighted ova may be nursed along to term and result in monsters. Moreover, it is claimed<sup>29</sup> that 70 per cent of the fetuses are dead when the threat of abortion causes symptoms. However, Shute<sup>4</sup> in this country collected 443 cases treated with progesterone and/or wheat germ oil, of which only 2 per cent expelled fetuses which showed the slightest malformation, and Bishop<sup>2</sup> in England found but a single abnormal child—a case of pseudohermaphroditism. Because the placenta is normal in cases treated with progesterone, Reynolds<sup>31</sup> concludes that "the judicious use of progesterone assures to some unborn children the certainty of a life that would not otherwise be theirs".

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## THE A. M. A. MEETING IN ATLANTIC CITY

The 93rd Annual Meeting of the American Medical Association, held in Atlantic City June 9 to 12 inclusive, brought over 8,300 physicians to attend the meetings and exhibits. There were more than double that number of persons who visited Atlantic City for the meeting, counting members of the families, exhibitors, etc.

Dr. James Edgar Paullin of Atlanta, Ga., was elected to the office of President-Elect, and our own Dr. William J. Carrington of Atlantic City, Past President of The Medical Society of New Jersey, was chosen as Vice-President of the A. M. A. for the new administrative year. Our President, Dr. Marsh, greeted the visiting physicians at the Opening General Meeting on Tuesday evening. The A. M. A. will meet in San Francisco in 1943, in St. Louis in 1944 and in New York City in 1945.

The weather throughout the meeting was fine, and no great controversial matters marred the harmony which prevailed.

Representatives from the Philippines, Cuba and Puerto Rico were present. The Philippine representative, Dr. Dina, member of the House of Delegates, of the Philippine Medical Society, addressed the House of Delegates and also the Woman's Auxiliary of the A. M. A. He was enthusiastically received in both places and pledged the undying loyalty and support of his people to the United States of America—the mother country—and to its flag.

The local committees did a marvelous job in making the arrangements and keeping the program on schedule throughout the meeting. General satisfaction was expressed by those who were in attendance at the meeting. A total of 988 New Jersey physicians had registered up to the end of the fourth day at the A. M. A. headquarters, and no doubt an additional number registered on the last day of the meeting, which would give to New Jersey physicians a representation of over 1,000 who registered, plus that inevitable group who did not register though they attended some of the meetings.

The uniforms of the physicians in the Armed Forces were everywhere a reminder of the rapidly increasing number from New Jersey and other states who are already drawn away from their practices, and are a reminder to those of our profession who must remain at home of their increased responsibilities in the civil defense programs.

The *House of Delegates* emphasized the need for state and local adaptation of ways and means consistent with the policies and princi-

ples outlined by the national association, and the impracticability of preparing a national program for medical practice.

The National Physicians Committee for Emergency Medical Services was given full approval by the A. M. A., and women physicians were not endorsed for commission in the Armed Services, but were approved to serve in all forms of civil defense.

In the scientific aspects the new Section for General Practitioners of Medicine was a great success and will be continued. The interesting program provided and the great interest shown at this section meeting assure its permanent place in future programs.

The exhibits were larger than ever—both scientific and technical.

Motion pictures were featured at the A. M. A. meeting and are increasingly used in post-graduate medical training. They are especially valuable for refresher courses where time available is limited. Some excellent new films were shown at the meeting.

A session on Legal Medicine was held, at which were discussed many aspects of the problems with which the medical practitioner is periodically faced, and about which he has had little experience or training. Such problems as "Privileged Communications", "Law Versus Medical Ethics", "Legal Responsibility for Negligent Diagnosis"—this last was a subject upon which every doctor should become informed, for many physicians try to save money for the patient by omitting frequent x-ray pictures which would not only help the patient but protect physicians themselves against legal suits at a future time.

Dr. Harrison Martland of Newark illustrated the value of post-mortem examinations in cases of supposed suicide—some of which are confused with murder, and vice versa.

Demonstrations of the Kenny treatment for poliomyelitis were given.

Procurement and Assignment had booths in both the Scientific and in the Technical Exhibits. Those Government officials in attendance were kept busy advising physicians who presented their individual problems for advice as to procedure.

In addition to the sixteen specialized section programs, the interests of the *general practitioner, the backbone of medical practice and of organized medicine*, were well provided for at this meeting. This is a step in the right direction, but the general practitioner must in return himself become more active and better informed upon the aims and activities of his

medical societies if he is to hold and increase his influence in organized medicine.

The usual number of fraternity luncheons and medical college dinners were held and the President's Ball and Reception on Thursday night was well attended, as was the opening night program. The few war restrictions imposed did not interfere with the visitors' enjoyment of Atlantic City's many attractions.

Transportation difficulties involved made it impossible to fulfill the plans for a Pan-American Congress on the anticipated scale, but some of our Pan-American neighbors came in spite of the difficulties involved.

Altogether the 1942 Annual A. M. A. Convention was a successful and enjoyable occasion as was attested by all the physicians who attended the meetings.

## MEDICAL-SURGICAL PLAN OF NEW JERSEY

(A NON-PROFIT INSTITUTION)

### ORGANIZED WITH THE APPROVAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Medical-Surgical Plan has been placed in operation. It provides payment for medical and surgical services rendered bed-patients in hospitals. The Effective Date of the first contract certificate is July 1, 1942.

#### To the Profession:

Medical-Surgical Plan is your organization, organized to assist in the solution of your greatest problem, operated and controlled by the medical profession through The Medical Society of New Jersey.

Indifference and apathy on the part of individual physicians or groups can defeat its purpose—can defeat any attempt by the profession to solve its problems on a *voluntary* basis.

Add your name to our list of 2100 Participating Physicians Support, whole-heartedly the Medical Service Plan movement now operating in thirteen states with endorsement of their State Medical Societies;—not for your immediate personal welfare but for the future welfare of the private practice of medicine.

#### PROCEDURE

*Identification Card.*—Each Subscriber and insured Dependent will hold an Identification Card.

When applying for benefits your patient will present his identification card. Upon request by telephone or letter we will advise you on the status of the patient with the Plan, and the extent of available benefits.

*Notice of Hospital Admission.*—The hospital to which your patient is admitted will notify the Plan of his admission.

*Determination of Hospital Accommodations.*—It should be agreed between you and your patient, in your office or in the home of the patient prior to hospital admission, whether

your patient is to be admitted for private or semi-private hospital accommodations. Upon this decision depends whether you are accepting the patient on a "full benefit" or a "credit benefit" status.

*Semi-Private Accommodations.*—If your patient is admitted to the hospital for semi-private accommodations the payments you receive from the Plan for your services will be considered as payment in full.

*Private Accommodations.*—If your patient is admitted for private accommodations the amount of money specified in the schedule of benefits as applicable to the case will be credited by you to the patient. The remainder of your bill as agreed upon between you and your patient will be payable by the patient.

*Schedule of Benefits.*—The complete schedule is on file with the Secretary of your County Medical Society and in the office of the Plan. This should not be considered a "fee schedule". It represents the amount of money we should be able to pay for services providing our estimates are correct. Extracts from the schedule are as follows:

#### GENERAL MEDICAL

Initial hospital visit . . . . .	\$5.00
Subsequent hospital visits (one call daily)	3.00
Additional daily visits (one call daily)	1.50

#### GENERAL SURGICAL

Varies from \$5.00 to \$150.00, depending upon the type of case. A minimum of \$100.00 is payable for a laparotomy. Other benefits are in proportion.

We will be glad to furnish further information by correspondence or interview if you will address us at 31 Clinton Street, Newark, N. J.



## THE NEW JERSEY TUBERCULOSIS LEAGUE AND THE CONTROL OF TUBERCULOSIS IN NEW JERSEY

By B. S. POLLAK, M.D., F.A.C.P., Jersey City, N. J.

Talk delivered May 21, 1941, on behalf of the New Jersey Tuberculosis League, to the delegates and members of The Medical Society of New Jersey.

It is my purpose to explain how the New Jersey Tuberculosis League has coöperated with the doctors of New Jersey and how we have attempted to live up to the Medical Society's standards.

It was in 1885 that the unforgettable pioneer, Dr. Edward L. Trudeau of Saranac Lake (he was the first President of the National Tuberculosis Association) in his little red cottage initiated what is now recognized as "Sanatorium Treatment". And in 1906, a small group of medical leaders with some socially minded people of our state, organized the New Jersey Tuberculosis League, under the inspiring leadership of Dr. Gordon Kimball Dickinson, who in 1919 was President of The Medical Society of New Jersey. We desire here to record a word of tribute to Dr. Dickinson, one of the outstanding men of our profession to champion the cause of tuberculosis. In 1907, the sanatorium at Glen Gardner, under the capable leadership of Dr. Samuel B. English, was dedicated to the care of the curable tuberculous in this State. Dr. English is still an active and devoted advocate of high professional as well as institutional standards.

### LEGISLATION

In 1912 the State Mandatory Act made the counties, rather than the communities, responsible for the tuberculous in sanatoria. Since there were 565 cities, towns, or townships in the State, each with a local board of health, this legislation immediately gave a workable program for the control of this disease. This act also permitted the removal and restraint of recalcitrant patients. Only recently, however, has this been exercised to any great extent. As a result of this legislation, in addition to the state sanatorium, eleven counties have made provision for institutions which now have a total capacity of 3,387 beds. The other ten counties have made provision for their tuber-

culous in some of the institutions in the state and others in institutions in bordering states.

### RESOURCES

With the beds available in private institutions, in penal and mental institutions, New Jersey now has over two beds per death, which is the minimum standard set by the National Tuberculosis Association. The death rate has been reduced from 180 per 100,000 to 43.8 per 100,000 in 1940. Less than one-fourth as many deaths now occur from tuberculosis as in 1906 when the New Jersey Tuberculosis League was first organized, and this has come about largely through education of the masses by the earnest and sincere coöperation of the members of the State Medical Society.

### OUT-PATIENT SERVICE

Going hand in hand with the provision of the sanatorium beds has been the securing of clinics and nursing services for the medically indigent. In the beginning, visiting nurses' associations were called upon to render a great deal of bed-side care, but after the sanatorium beds became available, this practice was discouraged. There was a need, however, for clinics where patients could go for an examination and for nurses to follow up these patients, secure admission to sanatoria, and give home advice when necessary. With the extension clinics of the State sanatorium, county clinics and local clinics, we feel that the State is now adequately covered with clinic and nursing service. The 87 clinic centers in the State serve 42,485 patients who made 107,233 visits to the clinics.

There are about 200 public health nurses who follow up and advise these patients in the home in coöperation with the family physician.

In 1939, 41,742 visits were made by these nurses on 10,976 tuberculosis cases on the home visiting register, which includes many private

physicians' cases. In addition, there were many thousands of visits made on contacts and those who came in for an examination who were found to be free of tuberculosis. It is now possible for anyone who may have symptoms of tuberculosis to get expert medical diagnosis and we feel sure that with the corps of nurses available we can provide adequate supervision in the home which is lessening, and, no doubt, preventing such infection in the family.

With the provision of an adequate number of sanatorium beds with clinics scattered over the state, making it easy for patients to secure an early diagnosis and with a large corps of nurses to supervise patients in the home, one might think that the tuberculosis problem was well in hand. Yet we find that on an average only about 10 per cent of those admitted to our sanatoria are in the minimal stage, while about 60 per cent of them are in the far advanced stage, and 30 per cent moderately advanced.

#### TUBERCULOSIS AMONG SCHOOL CHILDREN

Because of the continued number of advanced and moderately advanced cases, and by experience gained in the various sanatoria that an appreciable number of these patients were of the teen age group, we instituted among the laity as well as among the profession, a movement to ascertain the rate of infectivity among high school pupils. The Advisory Committee on Tuberculosis of the New Jersey Tuberculosis League, composed mostly of the sanatoria directors, together with a similar committee of The Medical Society of New Jersey, submitted its opinion regarding the advisability of adopting tuberculin testing and of x-raying students of the high schools, to the Committee on Public Health which, in turn, recommended this plan to the Welfare Committee of the Medical Society. The latter enthusiastically adopted the plan and authorized the Chairman of the Advisory Committee on Tuberculosis to enlist the support of the county medical societies. This measure received the whole-hearted support of the profession. In this connection we desire to pay tribute to Dr. A. E. Jaffin, chairman of the committee, and his co-workers for the splendid services they

have rendered both to the profession and to the public.

Stimulated by the findings obtained, the New Jersey Tuberculosis League, with the coöperation of our late associate, Dr. Ireland of the State Board of Education, and with the aid of Dr. Lawton, President of the State Board of Medical Examiners, formulated measures to make tuberculin testing and x-raying of reactors of the children of the public schools as well as examination of the school personnel, mandatory. Thanks to Senator Bowers of Somerset County, an Act approved by our organization was introduced, which has since become a law.

In passing, I trust I may be pardoned in rejoicing over the fact that it was my personal privilege to assist in the fruition of this effort. New Jersey stands in the forefront in regard to such progressive legislation. In connection with this matter I desire to acknowledge the outstanding aid which was given by Dr. Fred-eric J. Quigley, Past President of our Medical Society, and by Dr. Samuel Alexander, whose efforts and coöperation made possible the adoption of this Act.

During the past few months, Professor Meyers of Minnesota and many others have written to me to ask about the legislation adopted here in order that they might be able to introduce similar measures in their states. Nearly every community has entered into this program heartily. Early reports from some of the counties indicate that the amount of infection has been reduced to about 15 per cent. We are well on the way with a plan that will perhaps make it possible to endorse the opinion of Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, who states that if we use the knowledge now available and carry on mass testing programs among the low-economic group, we may anticipate the eradication of tuberculosis by 1960. This, perhaps, is too optimistic a view. However, the late President Chadwick of the National Tuberculosis Association likewise expressed the opinion that by the end of the century, the elimination of tuberculosis will be well within the scope of possibility.

### COMING OBJECTIVES

New Jersey is well in the forefront of progressive effort which is being expended by official and non-official agencies in attempting to discover tuberculosis among the masses. Its hospitalization program is in keeping with the accepted standards. Hospitalization offers the best method in a program destined to bring about the arrest of tuberculosis among our people.

Our coming objective must be in the direction of case findings, and to obtain the greatest success, concerted effort must be directed through educational propaganda by the medical men of our state.

### TUBERCULOSIS IN THE ARMY

The experience of the last World War indicated that many tuberculous men were drafted into the Army and in consequence were a great expense to the government. It was therefore suggested that our Advisory Committee on Tuberculosis interest the Medical Society in a program whereby the draftees might be x-rayed before induction. As a result, early last October the Committee on Tuberculosis of The Medical Society of New Jersey urged that the Society, through the Committee on Medical Preparedness, make arrangements for the chest x-ray of every man prior to induction. By the end of October there was received from the Surgeon-General of the Second Corps Area a communication that the Army would welcome this effort until they could set up their own equipment and personnel. In November a joint meeting of the Medical Preparedness Committee and the Advisory Committee on Tuberculosis was held and ways and means were provided for x-ray services at the four induction stations: Newark, Trenton, Somerville and

Camden. Drs. Collier, English, Morrow, Runnell, Kruger and Harmon were appointed to take charge of this project in these stations. The total number of draftees x-rayed from November 25th to March 14th at these stations was 14,552. Of this number, 98 cases of tuberculosis were discovered, making an incidence of 0.67 per cent or almost 7 cases per 1,000 men. An additional 364 men of the New Jersey National Guard troops (colored) were also x-rayed, revealing six more cases.

### GRADUATE EDUCATION

Post-graduate courses in tuberculosis have now been instituted in order to give an opportunity to the profession to avail themselves of the facilities in the respective institutions.

### CHEST X-RAYS

The value of chest x-rays in the apparently well as the best method of finding cases of tuberculosis has been definitely established. The fact that most cases found are in the minimal stage and promptly curable makes this method all the more valuable. Most of the cases thus found will naturally seek the advice of private physicians. It is to be hoped that these findings will not be minimized because of the lack of clinical signs or symptoms but will be given due consideration. There is need for a better understanding of this problem by all of us. Objections based on erroneous economic ideas are retarding a most productive means of case finding that would be to the reciprocal advantage of the public and the profession.

The 1941 slogan adopted by our committee—"A good x-ray is your doctor's best aid in discovering early tuberculosis"—confirms the above conclusions and deserves the united support of the entire medical profession.

100 Clifton Place

**DURING THE NATIONAL EMERGENCY WE** will either make great gains or suffer great losses in our fight against tuberculosis. The gains will come from the chest x-ray examination that will be given the young men entering military service . . . the real losses will come if industry does not adopt the practice of x-raying employees. 'The

massing of labor in concentrated areas creating crowded living conditions, increased mental, emotional and physical strain—inevitable by-products of industrial defense activities—are factors which increase and spread tuberculosis.—Kendall Emerson, M.D.



## THE EDWARD J. ILL AWARD

CITATION BY DR. WELLS P. EAGLETON

Hawkes, more than a half a century has passed since you and I first looked into each other's minds, felt the impulse of each other's motives, and examined the channels that we



desired our lives to take. All these years I have found much pleasure and profit in communing with you about life, about fun, about the world here and to come, but through it all there al-

ways ran thoughts of *our own walk* in life,—the daily practice of medicine, ordained of God when piloted by the oath of Hippocrates: "I will teach this art to my sons and to those of my teachers *without fee or stipulation*."

And I welcome this opportunity here to testify publicly that Northern New Jersey has been blessed beyond measure to have had among us a man and a surgeon of such industry, of such intellectual integrity, of such determination.

For you have been a real man and you have tried to be true to your Hippocratic oath—"to practice your art in purity and holiness". And in your daily practice, in an age of materialism, when some of those in high places in organized medicine have been guilty of the most disgraceful—yes, "criminal methods" of—commercialism, you have labored not for yourself but for those ideals formulated by our Colonial doctor—forbears here in the Province of New Jersey in 1766, ideals of (1) "mutual improvement", (2) the "advancement of the profession", and (3) the "promotion of the public good", and with them you have "invited and urged every gentleman of the profession" to become associated with you and your fellow-doctors.<sup>1</sup>

## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

This list covers May and June, 1942:

BERNSTEIN, A. (Newark)—See Parsonnet, A. E.

BOYER, PAUL K. (Summit) (with Cameron V. Bailey, N. Y.)

Concentration of carbon dioxide in expired air. Arch. Int. Med. 69:773-788, May 1942

CANTAROW, A.—See Haury, Victor G.

FORD, NORMA. Ph.D. (Toronto), and FRUMKIN, SYLVIA, M.A. (Greystone Park)

Monozygosity in mongoloid twins. Am. J. Dis. Child. 63:847-858, May 1942

FRUMKIN, SYLVIA (Greystone Park)—See Ford, Norma

GOLDSTEIN, HYMAN I. (Camden)

Max Einhorn, M.D., on the eightieth anniversary of his birth. Rev. Gastroenterol. 9:203-206, May-June 1942

HAURY, VICTOR G., and CANTAROW, A. (Audubon)

Variations of serum magnesium in 52 normal and 440 pathologic patients. Jour. Lab. & Clin. Med. 27:616-622, Feb. 1942

NAYLOR, MILDRED V. (Newark), Librarian, Academy of Med.

Sylvester Graham, 1794-1851. Ann. M. Hist. 4:236-240, May 1942

PARSONNET, A. E., and BERNSTEIN, A. (Newark)

The management of cardiovascular syphilis. Urologic and Cutaneous Review, 46:375, June 1942

REITMAN, NORMAN; GREENWOOD, W. RUSSELL, and

KLER, JOSEPH H. (New Brunswick)

Coronary thrombosis in a young diabetic. Am. J. Med. Sci. 203:792-796, June 1942

1. "Instruments of Association and Constitutions of the New Jersey Medical Society," in Wickes, Stephen: History of Medicine in New Jersey, and of Its Medical Men, Newark, N. J., 1879, pp. 44-48.

## "WELL DONE, THOU GOOD AND FAITHFUL SERVANT"

On May 21st, The Academy of Medicine of Northern New Jersey presented The Edward J. Ill Award to Dr. E. Zeh Hawkes as the man whom they had chosen to receive this year the honor "for extraordinary services as a physician and as a citizen".

Dr. Wells P. Eagleton made the citation, as was eminently fitting, for he was the colleague of closest and longest association with Dr. Hawkes. The Academy members and friends were joined by a host of admirers of the honored guest in a fitting tribute to one well deserving of public acclaim. In the citation were revealed many of the contributions of Dr. Hawkes concerning which the medical profession itself knew too little. Such contributions as the honored guest made to the extension of opportunity to physicians to attend their own patients in certain hospitals and to profit from the training were a result, in part he insists, of Dr. Hawkes' personal interest and sustained efforts. His more recent contributions to such modern problems as improving the distribution of medical service to all in need thereof at a cost which each can afford to pay were likewise modestly made and never publicized.

Dr. Hawkes' contributions in other fields were revealed by the President of Union College, of which Dr. Hawkes is a Trustee and graduate. President Fox spoke of the sound advice and assistance ever available to his Alma Mater from his friend and ours, the guest of the evening.

In a characteristically modest fashion Dr.



Hawkes sought to share all credit with those associated with him in the various enterprises recounted but he was among friends who knew him and his facetious thrusts at his old friend, Dr. Eagleton, as the latter revealed Dr. Hawkes' many-sided interests and activities, served only to endear him to those present.

## THE MEDICAL SOCIETY OF NEW JERSEY SUPPLEMENTARY LIST OF MEMBERS NO. 3

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### ACTIVE MEMBERS

Arlitz, William J., 275 Boulevard, Bayonne (9)  
Balles, Edward, 295 Broadway, Paterson (16)  
Bregman, Milton, 81 Union av., Manasquan (13)  
Butler, Samuel S., 1100 Kaighn av., Camden (4)  
Caldwell, Julius A., 45 S. Mountain av., Montclair (7)  
Carr, Alexander M., S. Main st., Metuchen (12)  
Comora, Herman C., 317 60th st., W. New York (9)  
Danzis, Louis, 744 Broad st., Newark (7)  
Davis, Daniel, Ill. Facility Vet. Adm., Hines, Ill. (9)  
DiNocchia, Joseph, 498 W. Market st., Newark (7)  
Dunham, Malcolm M., 88 Grove av., Woodbridge (12)  
Farkas, Morris, 163 High st., W. Orange (7)  
Garrison, George H. H., Cooper Hosp., Camden (4)  
Kilborn, Melville G., 7 Gilbert pl., W. Orange (7)  
Kirkwood, Allan S., 53 Union st., Montclair (7)

Klughaupt, Dorothy K., 49 Passaic av., Passaic (16)  
Landis, Harry P., Jr., 901 Columbia av., Palmyra (3)  
Lang, Joseph, 111 Market st., Perth Amboy (12)  
Lepus, Alphonse A., 89 Danforth av., Jersey City (9)  
Lomhoff, Irving L., 84 Osborne ter., Newark (7)  
Mulvihill, William J., 275 Boulevard, Bayonne (9)  
Murray, E. N., 558 Newton av., Camden (4)  
Nataro, Joseph, 172 Littleton av., Newark (7)  
Nears, Clifford R., 2 Hawthorne av., E. Orange (7)  
Opfermann, John L., 167 Bay av., Highlands (13)  
Parkes, Morey, 33 Park av., Caldwell (7)  
Penchansky, Samuel J., Station Hosp., Keesler Fd., Biloxi, Miss. (9)  
Pentel, Louis S., 307 60th st., West New York (9)  
Pinto, Joseph A., 50 N. 11th st., Newark (7)  
Potter, Charles W., Belvidere av., Washington (21)  
Richardson, Arthur H., 60 Orange rd., Montclair (7)

Robertson, Eugene V., 171 Diam'd Br. av., Hawth'ne (16)  
 Romano, Michael, 182 Willow st., Yonkers, N.Y. (16)  
 Smalley, Sara D., 530 Clifton av., Newark (7)  
 Solworth, Lee, 100 E. Palisade av., Englewood (2)  
 Trippe, Morton F., Medical Corps, Port of Embark.,  
 Brooklyn, N. Y. (13)  
 Wegrocki, Adolph A., 588 Sandford av., Newark (7)

## ASSOCIATE MEMBERS

Fischer, Louise, 25 Van Velsor pl., Newark (7)  
 Mazzarella, Carlo, 237 Broadway, Paterson (16)  
 Monaco, Dante P., 437 N. 13th st., Newark (7)  
 Scalera, John F., Demons. Reg., A.F.S., Ft. Knox,  
 Ky. (7)  
 Sperling, Irving L., 62 Lyons av., Newark (7)

## MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES

### SUPPLEMENTARY LIST NO. 2

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Anderson, Richard D., Burlington (3)  
 Barkhorn, Charles W., Newark (7)  
 Barnard, Frank G., Montclair (7)  
 Bauman, Everett O., Newark (7)  
 Berman, Sol, Elizabeth (20)  
 Boquist, Walter A., Phillipsburg (21)  
 Boselli, Emile H., Union City (9)  
 Colton, Ethan T., Jr., Montclair (7)  
 Cooper, Irving J., New Brunswick (12)  
 Danzis, Louis, Newark (7)  
 Darby, I. Kermit, Newark (7)  
 Davis, Daniel, Jersey City (9)  
 DePalma, Anthony F., Newark (7)  
 DiNorcia, Joseph, Newark (7)  
 Driscoll, Charles D., West Collingswood (4)  
 Dunham, Malcolm M., Woodbridge (12)  
 Edlkraut, Edward, Passaic (16)  
 Fine, Irvin J., Perth Amboy (12)  
 Fridrich, Harry E., Camden (4)  
 Friedman, Milton, Newark (7)  
 Gerner, Harry E., Jersey City (9)  
 Gibbins, A. Leslie, Newark (7)  
 Goldman, Sol B., Paterson (16)  
 Gordon, Abel, Passaic (16)  
 Graham, Ernest E., Yardville (11)  
 Gruber, William L., Newark (7)  
 Hnat, Frederick, Elizabeth (20)  
 Holster, Stephen G., Paterson (16)  
 Humbert, Joseph, Stewartsville (21)  
 Irmsch, George W., Trenton (11)  
 Kelly, Leo J., Perth Amboy (12)  
 Kessler, Henry H., Newark (7)  
 Knowles, James S., Millville (6)  
 Kuperman, Henry L., Newark (7)  
 Kushner, Alexander, Rahway (20)  
 Lapin, Louis P., Bordentown (11)  
 Lapin, Samuel B., Trenton (11)  
 Lloyd, Samuel J., Trenton (11)

Lobban, Robert B., Jersey City (9)  
 Lomhoff, Irving L., Newark (7)  
 Lucey, James J., Perth Amboy (12)  
 MacArt, J. Harold, East Orange (7)  
 Marquis, Dean W., East Orange (7)  
 Maxwell, Carl A., Hackettstown (21)  
 McCall, Jesse, Newton (19)  
 McLean, Hugh A., West New York (9)  
 Meyer, Eugene A., Moorestown (3)  
 Murray, E. N., Camden (4)  
 Patterson, Isaac N., Westville (8)  
 Penchansky, Samuel J., Bayonne (9)  
 Pinto, Joseph A., Newark (7)  
 Pollock, Theodore, Clifton (16)  
 Price, H. Preston, Jersey City (9)  
 Probst, Everett W., Rutherford (7)  
 Richards, Paul S., Butler (16)  
 Rieman, Aloysius P., Jersey City (9)  
 Romano, Michael, Paterson (16)  
 Scalera, John F., Newark (7)  
 Schaffer, Barney, Belleville (7)  
 Schellenger, E. A. Y., Merchantville (4)  
 Shangold, Jack E., Sergeantsville (10)  
 Silberner, Herbert B., Newark (7)  
 Simon, Julius J., Passaic (16)  
 Sirotta, E. Bernard, Paulsboro (8)  
 Smith, J. Meredith, Hackettstown (21)  
 Solworth, Lee, Englewood (2)  
 Sperling, Irving L., Newark (7)  
 Sutton, Harold L., Newark (7)  
 Tirrell, C. Malcolm, Newark (7)  
 Trippe, Morton F., Neptune (13)  
 Vanderbeck, James J., Paterson (16)  
 Waldron, Edward L., Trenton (11)  
 Waldron, Robert E., Newark (7)  
 Weissberg, William M., Hillside (20)  
 Wethers, William A., Passaic (16)  
 Wikoff, John L., Trenton (11)  
 Yuckman, Robert O., Elizabeth (20)

## NEONATAL DEATHS IN NEW JERSEY IN 1940

This is a summary of investigations on all the deaths in New Jersey under the age of one month. Information was obtained from questionnaires sent to hospitals and physicians.

In 1940 there were 1,386 deaths under one month,—information was obtained with reference to 1,219.

This study was made because the deaths in the first month represent approximately two-thirds of all the deaths in the first year. It is recognized that any further reduction in mortality in the first year of life must come from a reduction in the first days and weeks of life.



Consideration of some of the facts obtained may lead to this result:

#### 1. ATTENDANT AT BIRTH

Ninety-five per cent of these births were attended by physicians and 79 per cent delivered in hospitals; midwives attended only 2 per cent.

#### 2. AGE AT DEATH

Sixty-three per cent of the deaths under one month occurred on the first day of life, and 87 per cent occurred in the first week.

#### 3. CAUSE OF DEATH

In 53 per cent of these deaths prematurity was given as the cause; birth injury in 75 per cent. These are largely clinical diagnoses as autopsies were performed in only 15 per cent of the cases.

#### 4. PRENATAL CARE

From the reports it appears that 70 per cent of the mothers of the infants had prenatal care, with 57 per cent having received this care before the sixth month of pregnancy. The records indicate that at least 75 per cent of the women received one examination during pregnancy.

#### 5. SYPHILIS

Tests for syphilis were made in 1,059 or 87 per cent of the cases. Only 20 positive reactions were reported or 1.7 per cent of the group. This coincides with the general experience that syphilis is rather a small factor in neonatal deaths.

Since 63 per cent of the deaths under one month occurred in the first day, it is desirable to consider the relationship of complications of pregnancy and labor in relation to them.

#### 6. COMPLICATIONS OF PREGNANCY

Complications of pregnancy were reported in 27 per cent of the cases; of this group 38 per cent had hemorrhages; 17 per cent toxemia; 8 per cent nephritis.

#### 7. COMPLICATIONS OF LABOR

Complications of labor were reported in 363 instances or 29 per cent of the total group. Hemorrhages were reported in 19 per cent of the cases, and dystocia in 18 per cent.

Labor was induced in 80 of the cases or 5 per cent of the entire group.

#### 8. OPERATIONS FOR DELIVERY

Operations were listed in 243 cases or 20 per cent of the group. There were 66 Caesarians, 57 episiotomies, 96 forceps, 17 versions.

In percentage this would indicate that there were about 6 per cent Cesarean sections among these deaths under one month.

#### 9. BIRTH WEIGHTS REPORTED FOR 1,022 INFANTS

Birth weights are important since it has been found that the mortality in premature babies decreases as the weight of the infants increases. While the mortality of infants weighing less than two pounds is usually 97 per cent, the mortality of premature infants weighing over four and one-half is 8 per cent.

In this series 10 per cent of the infants weighed less than two pounds, 15 per cent between two and three pounds, 16 per cent between three and four pounds, 14 per cent between four and five pounds, and 42 per cent over five pounds.

It has long been recognized that infant mortality among colored infants is two or three times as high as the white. Part of the answer can perhaps be found in the fact that a much higher percentage of the colored infants are found in the lower weight groups.

A recent study in New York of the births has shown that about three times as many colored infants weighed less than two pounds at birth.

In this series, the percentage of white infants under two pounds at birth was 8, and that of the colored 20; between two and three pounds, for the white 14 and for the colored 24.

While 44 per cent of the white infants that died under one month weighed more than five pounds only 29 per cent of the colored weighed more than five pounds.

#### 10. ASPHYXIA

It is the opinion of many of the students of this problem that asphyxia is the predominant cause of early infant mortality.

A very careful study carried out in Glasgow several years ago gave the figure as 67 per cent. Anesthetics and sedatives contribute to incidence of asphyxia. In this study it was found that 43 per cent of the mothers had received some form of sedative drug or anesthetic. Of this group of 533, it was found that 37 per cent had received ether, 22 per cent nembutal, 15 per cent morphine, 7 per cent scopolamine, 6 per cent nitrous oxide, 4 per cent sodium pentobarbital, 4 per cent codine, 3 per cent chloroform, and 28 per cent other drugs, such as sodium allurate, sodium amital, ethylene, etc. Several of the mothers received more than one drug.

Dr. Cole of Detroit compared the degree of asphyxia in infants delivered by Caesarean sections according to the method of anesthesia.

He found a much higher incidence and a greater severity of asphyxia among infants whose mothers had received ether than among mothers who receive scopolamine.

I mention this to suggest that perhaps a more careful study and greater care in the use of these various drugs may help to reduce some of this early mortality.

#### 11. FEEDING OF INFANTS LIVING OVER 24 HOURS

From the reports it was found that only 28 per cent of the babies were breast fed entirely, and that 45 per cent were entirely bottle fed.

I am not quoting these figures to prove that

feeding is cause of early deaths, but merely to indicate the high percentage of artificial feeding in new-born.

In the questionnaires physicians were asked to mention contributing factors in these deaths. The following list might suggest methods of improving care of the newborn:

No medical care .....	9
Lack expert consultation .....	4
No hospital facilities .....	4
Lack proper facilities in hospital .....	6
Family ignorance and neglect .....	115
Inability to pay for care .....	5
Other factors .....	153

## MEDICINE FACES THE FUTURE

LEROY A. WILKES, M.D., Executive Officer

The medical profession in New Jersey and in other states is now truly at the crossroad, and is increasingly feeling the competition of governmental agencies. There is a natural desire on the part of administrators charged definitely with heavy responsibilities, to obtain the controls necessary to the economical and efficient discharge of their duties. It is amply demonstrated that though the medical profession could furnish practically all the medical services needed in the state and community, the members of "Organized Medicine" are under no effective controls to insure prompt and economic results, and no effective disciplines can be applied by their elected or appointed officers, since the membership is voluntary and practicing members who give their services to the society and the public are not paid. The income of the society is chiefly from the members' own contributions.

Governmental administrators, on the contrary, are especially trained for this special work and are paid. They have back of their orders and direction, either legislation or decrees giving the necessary authority for control. They also have the funds needed to carry on the work assigned, and the understanding support of other trained administrators on their government boards, men who are experienced in the best methods of distributing services to groups at low per capita cost to the group, only a small percentage of whom individually, in any given year, need the specific services provided. "Fee for service" is undoubtedly in principle a fair basis of charge, but does permit of wide variation in charges for the same service. It is very expensive to admin-

ister, supervise and obtain proper records both in financial and of results achieved from such a system of practice. This is the "Laissez faire" method so long in use by the professions and by business men, and which is now increasingly under attack by governmental authorities, and the public as being undemocratic, in spite of the fact that America itself is the outstanding product of such a system. The present-day trends are unquestionably away from this system and medicine too cannot escape the effect of these trends. It has already felt this influence. The Medical Society of New Jersey has gradually become convinced of the necessity to experiment as to the form of the changes necessary to conform to these trends. The very wealthy patient always could and still can maintain "free choice" in his selection of personnel, product and service. This group is, however, dwindling fast, and the profits from their patronage dwindle with them. It was these profits, or honoraria if you prefer, which alone made possible the very generous contributions of the medical profession to those who could not afford to pay. Service was truly given without cost to the indigent patient, but the public has come to regard these contributions as "free service" without cost consideration. Someone must always pay the cost represented in the service. To their everlasting credit this cost has been long borne by the profession in its charitable contributions made to the indigent in need of their professional services. "Sweet Charity" is now a taboo word with professional salaried social workers—and it is true that their services are not a charity but a governmental service, paid

for by the public, which includes the physicians. Perhaps the time has come when the public is ready and willing to assume all costs of services rendered to the indigent public, and to pay for them out of the taxes collected.

Organized Medicine has not opposed this proposal. It has, in fact, approved it and has offered to continue its professional support if the quality of the service provided is preserved at the level prevalent in the outpatient clinics to which they have given their services, without charge, heretofore, in spite of the increasing load of the past decade or longer.

The profession itself has come to realize that "third parties", trained and experienced in the administrative work, can be helpful and assist both the physician and the patient in achievement of their respective aims. Hospitals, Public Health Departments, even medical societies themselves and certain health service administrative groups operated by governmental or private agencies, bring doctors and patients together for effective and economic treatment as needed, and distribute the increasing costs of medical care more equably for all concerned. These aims are not inconsistent with the aims of the profession. Many physicians have become recognized leaders in this newer administrative field and are endeavoring to help in the necessary evolutionary changes involving the distribution of medical care, as agreeable and efficient as possible for the public and their colleagues in private practice. This fact seems difficult for some of their colleagues to grasp, and this fact has delayed their accomplishment of the objective set.

Because of the advantages mentioned at the beginning of this article, an increasing number of medically trained executives have been drawn into governmental departments and have been most instrumental in the increasing direction and control of group medical services by these departments. Perhaps it is well that such men have been in charge of the inevitable and evolutionary changes made, else more drastic and unwelcomed opposition might have developed and medical influence might have still further declined in the last decade. The general practitioner of medicine is trained as an individual, responsible for the welfare of the person who seeks his professional advice and care. Hence these physicians individually feel that their proper scope of function begins when the patient first calls on him at his office or demands his services at the patient's home. The specialist in the larger cities sees many patients of other doctors, in consultation, and in this way is selected by the practitioner

rather than by the patient himself. The practitioner and specialist in the larger cities develop more teamwork with their colleagues, with those in allied fields, and those in other agencies engaged in Community Health Programs. These physicians recognize the value of time schedules, work plans, prompt dispatch of scheduled time and the full use of lower-cost assistants and technicians in their work. These are business methods of equal value to physicians as well as to others who wish to conserve time and effort. It is for this reason that the majority of the physicians in evidence on committees, and as officers of the State and larger County Societies, are specialists or city practitioners. They are more experienced in teamwork and are usually better prepared to fit in with the new order *when* it comes. The Medical Service Administration is about ready to begin operations. From this point on, the individual participating physician will play the most important part in determining the success or failure of this effort. Whether the considerable sum invested to date shall prove to be an investment or a loss depends upon the participating physician's prompt and effective coöperation, contribution of proper records and persistent teamwork. Early misunderstandings and mistakes are to be expected but with proper attitude and earnest effort on both sides, these can be overcome and success achieved, with resulting mutual benefit to subscribers and participating physicians. The war experience upon which many of our members are now entering will provide many doctors with a better understanding of organized effort, and the records essential to accomplishment; with an appreciation of the value of time and the economical use of equipment; and more than any other one thing the need to keep out of a rut in one's thinking and planning, so as to be able and ready to meet the unexpected development as it occurs and still be in stride and ready for the next problem when it comes. Much good as well as individual sacrifice will come out of army experience in medical care. While in the service *for the duration*, one should not worry much about the future trends of medicine. The whole future of our country hinges upon each playing his own part right now, wherever he may be. The improvement in Organized Medical Care will be evident after the war. Those who stay behind to carry on the work will do all in our power to keep well-qualified medical men in the councils which govern medical effort both in Civilian Defense and in the Armed Forces who sweep on in the offense soon to begin.



## OBITUARIES

## DR. EDWARD J. ILL

New Jersey has suffered an irreparable loss in the death of Dr. Edward J. Ill of Newark. Dr. Ill's contributions to the medical profession, both personal and professional, during his long life are well known to the members of The Medical Society of New Jersey and the profession generally.



Dr. Ill graduated from the Medical Department of Columbia University of New York City in 1875. He studied abroad in Strassburg, Vienna and Freiburg, Germany. At the time of his death he was 88 years of age and had practiced medicine in New Jersey for 65 years, having started practice in Newark in 1877.

Dr. Ill was a Past President of the Essex County Medical Society and The Medical Society of New Jersey. In 1893 he was Vice-President of the Pan-American Medical Congress, and President of the American Association of Obstetricians and Gynecologists in 1899, member of the Southern Surgical and Gynecological Association, State Chairman of the American Society for the Control of Cancer, member of the Board of Governors of the American College of Surgeons. He was for many years Policyholder Director of the Prudential Insurance Company, former Surgeon to the Women's Hospital, Medical Director of St. Michael's Hospital, Gynecologist, Supervising Obstetrician and Trustee of St. Barnabas Hospital. He served as Consulting Gynecologist to the Beth Israel Hospital of Newark, the All Souls' Hospital, Morristown; Mountain-side Hospital of Montclair, Rahway Memorial Hospital of Rahway; President of the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey.

In 1934 a bust of Dr. Ill was presented to the Academy of Medicine, of which he was the first President, to mark his eightieth birthday, and upon his completion of 58 years of service on the Staff of St. Barnabas Hospital for Women and Children his portrait was presented to the hospital.

A special award in his honor was created by the Academy of Medicine and a replica of the presenta-

tion of this plaque was made to Dr. Ill on his eighty-fifth birthday in 1939.

The Essex County Medical Society presented to Dr. Ill a scroll of appreciation in recognition of his completion of more than fifty years in the practice of medicine. An award was made to him by The Medical Society of New Jersey as one of the four outstanding physicians, with the citation "for contribution to the progress of scientific medicine".

Dr. Ill was a tireless worker during his long period of activity, yet in his busy life he included yachting, gardening and other outdoor activities along with his research and interest in the civic affairs of Newark, where he frequently served in an official capacity.

With Dr. Henry L. Coit he helped establish certified milk. He led in the development of specialization in medicine and in the development of modern laboratory aids to medical practice.

During his lifetime Dr. Ill presented more than \$20,000 worth of rare medical volumes to the Academy of Medicine of Northern New Jersey. He was a Fellow of the American College of Surgeons and the New York Academy of Medicine, a charter member of the Practitioners' Club of Newark and up to the time of his death he was a most helpful and active member of the Publication Committee of this Society.

He was the dean of a family of physicians and during his entire lifetime set an example to his profession.

## DR. WILLIAM W. BEVERIDGE

Dr. William W. Beveridge, 73 years of age, a pioneer Asbury Park physician who has practiced in that city for the past 42 years, died on June 10 in Asbury Park.

He was a native of Amsterdam, N. Y., and graduated from Princeton University in 1885. He received his medical degree from Bellevue Medical College in New York and came to Asbury Park, where he became associated with the late Dr. Samuel Johnson, whose daughter he married.

Dr. Beveridge, in addition to his professional interests, has a great interest and participated actively in civic affairs, frequently heading groups interested in the preservation of good municipal government. He was on the Staff of Fitkin Memorial Hospital, and is survived by his wife and five children.

## DECEASED PHYSICIANS OF NEW JERSEY

Name	Age	Date of Death	Residence	Cause of Death
Bernard Milnis	32	April 19	North Bergen	Myelogenous leukemia.
Albert Gallatin Stevens	72	April 17	Cape May	Myocarditis and arteriosclerosis.
Charles Day Moulton	66	April 11	East Orange	Arteriosclerosis, cerebral embolus, and chronic myocarditis.
Nelson A. Harris	81	April 9	Hackensack	Chronic myocarditis.
Peter E. Maras	57	April 6	Jersey City	Coronary thrombosis.
Edwin Glenn Smith	80	April 3	Atlantic City	Cardiac decompensation and arteriosclerosis.

## THE BULLETIN BOARD

"Belly-Acres", a residential estate in Silver Springs, Maryland, has been leased by a group of New Jersey physicians for the duration of their tour of duty at Walter Reed General Hospital. Those in residence at Belly-Acres are:

Major Charles W. Barkhorn  
Major E. W. Lance  
Major Hilton S. Read  
Major S. T. Snedecor  
Captain Ralph I. Alford  
Captain Ruffin Stamps

At the annual meeting of the New Jersey Society of Clinical Pathologists, the following officers were elected for the term 1942-1944:

President: Dr. Arturo Casilli, Elizabeth, N. J.  
Vice-President: Dr. S. A. Goldberg, Newark, N. J.  
Secretary-Treasurer: Dr. C. A. Pons, Asbury Park, N. J.

### PHYSICIANS ARE URGENTLY NEEDED

Army needs 20,000 physicians by December 31st. Five thousand are needed *immediately*. Read your A. M. A. Journal, The A. M. A. Association News, and your *Journal of The Medical Society of New Jersey* for information and guidance. For consultation on your *individual* difficulties call Dr. Charles H. Schlichter, 556 North Broad Street, Elizabeth, or Dr. N. M. Scott, 31 Clinton Street in Newark.

An interesting sidelight on the subject *Smoking in Wartime* has been recently thrown on the opinion of Gene Tunney, former heavyweight boxing champion, now in charge of the physical fitness program of the Navy. Regarding smoking, Dr. Louis E. Bisch, A.B., M.D., Ph.D. (Columbia University), a neurologist, has answered Mr. Tunney in defense of the habit in war time.

Mr. Tunney has followed the orthodox line of argument. Dr. Bisch has confined his arguments to wartime needs and conditions. The following excerpts from his answer are interesting if not convincing, since they appear in a popular weekly and are apparently not being ignored by the tobacco interests.

"The Lieutenant Commander (Tunney) apparently is not aware that we are fighting for the American Way of Life—not for a World's Series or a Heavyweight Championship. \* \* \*

Our boys are being conditioned for war, and in the last analysis they need mental conditioning as badly as they need the physical. They must be alert as well as strong. Mechanized war, the aeroplane, and the parachute require brains and coördination and a preponderance of superior equipment, even more than supermen of the muscular type.

"I have often heard American officers say soldiers are satisfied as long as they have food and cigarettes. Bataan's defenders had neither.

"There is a mental side to smoking which nobody should forget. MacArthur, in a recent conference in Australia, smoked five cigarettes in an hour and a half. President Roosevelt, Winston Churchill, Donald Nelson, Cordell Hull, General Knudsen, Admiral Hart, Chiang Kai-shek, Sir Stafford Cripps all smoke regularly. Incidentally, Hitler, Mussolini and Hirohito do not."

### AMERICAN RED CROSS SENDS DRUGS, MEDICAL SUPPLIES TO RUSSIA

Drugs, medical supplies and clothing valued at more than \$3,500,000 have been sent to the U. S. S. R. by the American Red Cross in recent months, it has been announced. Additional shipments are now being prepared, and it is anticipated that the amount of relief furnished will be approximately doubled within the near future.

Included among the drugs were 1,000,000 sulfapyridine, 4,000,000 sulfanilamide, and 1,500,000 quinine tablets, as well as 1,000 pounds of iodine. Among hospital supplies were 1,000,000 hypodermic needles, 200,000 hot water bags, 295,000 pairs of surgical gloves, 20,000 tourniquets, 60,000 syringes, 850,000 forceps, 100,000 rolls of adhesive plaster, 36,000 two- and three-inch bandages, and x-ray equipment valued at \$270,000. Shipments have also included 2,626,000 pounds of laundry and toilet soap, while 100 tons of surgeon's green soap are to be forwarded shortly.

Approximately 500,000 garments for men, women and children, in addition to shoes and blankets, have also been sent to Russia. Additional shipments of a like amount of garments are now being prepared.

Meeting of International College of Surgeons, National Assembly, Shirley Savoy Hotel, Denver, Colorado, June 15 to 18, inclusive. Panel discussions and operative clinics.

## COUNTY SOCIETY REPORTS

### ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

DR. ROBERT A. BRADLEY was elected President of the *Atlantic County Medical Society* for the ensuing year at the May 8th meeting of the Society, at the Traymore Hotel.

This was entirely a business meeting and was conducted by the outgoing President, DR. HARRY SUBIN. Dr. Bernard Crane read a resolution on the death of DR. SAMUEL STERN, a member of the Society.

The chief business of the meeting was the reports of the various committees, particularly the Nominating Committee. The following officers were unanimously elected and installed:

President, DR. ROBERT A. BRADLEY  
Vice-President, DR. THEODORE H. BOYSEN  
Secretary, DR. J. CARLISLE BROWN  
Treasurer, DR. DAVID B. ALLMAN  
Recorder, DR. SLOAN G. STEWART  
Historian, DR. H. H. HARLEY

Delegates to the State Medical Society, whose terms expire in 1945: DRs. EDWARD GUION, CLARENCE L. ANDREWS, BERNARD CRANE, WILLIAM HERSOHN.

Alternates: DRs. COLE DAVIS, HAROLD DAVIDSON, LE-  
LAND S. MADDEN, ILY R. BEIR.

Board of Censors: DR. EDWARD F. UZZELL, Chair-  
man; DRs. V. EARLE JOHNSON, HARRY SUBIN.

Executive Committee: DR. ROBERT A. BRADLEY,  
Chairman; DRs. THEODORE H. BOYSON, J. CARLISLE  
BROWN, DAVID B. ALLMAN, BERNARD CRANE (1943),  
PETER MARVEL (1944), LAWRENCE WILSON (1945).

DR. BRADFORD A. WEEKS of Pleasantville was  
elected to membership in the Society and DRs. J. C.  
McCRACKEN and MAURICE B. GORDON to associate  
membership.

The Society gave DR. HARRY SUBIN a rising vote  
of thanks for his faithful and excellent service to  
the Society during his year as President.

There was also a special meeting of the doctors  
of Atlantic County held on May 15th at which the  
urgent need for Army doctors was expressed by  
CAPTAIN ROBERT H. LOWE, of Station Hospital, Fort  
duPont, Delaware City. Col. of the Officers Re-  
cruiting Board for Southern New Jersey and Dela-  
ware. More than 100 doctors listened as he pointed  
out that the Army needs more than six doctors for  
each 1,000 men. He strongly urged the voluntary  
application by doctors for commissions rather than  
to wait to be drafted into the Army without a com-  
mission. Dr. Robert A. Bradley, the newly elected  
President of the Society, presided.

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The May meeting of the *Burlington County Med-  
ical Society* was held on May 14, 1942, at the River-  
ton Country Club, Riverton, N. J. This was the  
last meeting before the summer recess.

PRESIDENT LEFAVOR welcomed the following guests:  
DRs. GEORGE GERMAN and RAUL BETANCOURT of Cam-

den County; DRs. WOOD, DIVERTY, ULMER, NELSON  
and CAPT. FISHBEIN from Gloucester County; DR.  
LLOYD GREENE of Philadelphia; DR. ALAN HEMPHILL  
of the Burlington County Hospital; and COL. HAINES  
from Fort Dix.

A letter from DR. J. LYNN MAHAFFEY stated that  
a venereal disease clinic would be started at the  
Burlington County Jail and asked that two physi-  
cians be recommended to fill the position.

DR. LEFAVOR introduced CAPT. ROBERT H. LOWE  
of the U. S. A. Surgeon General's Office. Capt. Lowe  
stated that the Army is in *urgent need* of physi-  
cians and advised that physicians avail themselves  
of the opportunity to secure a commission.

In his farewell address, the retiring President,  
DR. DEAN H. LEFAVOR, thanked all the officers of  
the County Society and the chairmen of the various  
committees for their very valuable help. He sug-  
gested that the physicians who remain at home  
should impress upon the public the need to be  
more considerate of the doctor's time because the  
ones who stay home will have much more to do.  
DR. LEFAVOR expressed the hope that physicians  
would coöperate more among themselves in these  
trying times. He urged the members of the County  
Society to write more prescriptions and to use less  
proprietary preparations. The last point of his  
speech was a warning that all of us must work  
against the development of socialized medicine.

The new President, DR. PARRY M. SCOTT of Bev-  
erly, was introduced by DR. LEFAVOR. DR. SCOTT  
made a short speech of acceptance. A gavel was  
presented to DR. LEFAVOR by DR. SCOTT on behalf  
of the Society in appreciation of his services as  
president.

DR. FRANZ J. POLGAR was introduced by DR. SCOTT  
and provided the entertainment of the evening by  
presenting "Miracles of the Mind". DR. POLGAR  
mystified his audience by amazing memory feats  
and telepathy.

MRS. WILLIAM BRAY, President of the Woman's  
Auxiliary, thanked the Society for inviting the  
ladies to this meeting.

The County Society approved the licensing of  
Mrs. Stackhouse's Maternity Home in Burlington  
for four patients.

The next meeting of the County Society will be  
held in September.

### CAMDEN COUNTY

Thomas H. McGlade, M.D., Reporter

The Annual Meeting of the *Camden County Med-  
ical Society* was held in the City Dispensary Build-  
ing on May 5, 1942, at 9 p. m., with DR. D. F. BENT-  
LEY presiding.

DR. J. S. SHIPMAN read the report of the Nom-  
inating Committee, which was accepted unani-  
mously and the ballot cast by the Secretary. The  
following officers were elected:

President, DR. D. F. BENTLEY  
President-Elect, DR. T. M. KAIN  
Vice-President, DR. G. F. WEST



Secretary, DR. V. DELDUCA  
Treasurer, DR. E. C. SHULL  
Reporter, DR. T. H. MCGLADE  
Historian, DR. H. B. DECKER  
Trustee, DR. O. W. SAUNDERS  
Censor, DR. A. L. STONE

Delegates to N. J. State Medical Society: DRs.  
HELEN SCHIRACK, H. TATEM, A. B. DAVIS, M. L.  
WEIMAN, H. W. JACK

Alternates: DRs. C. E. PIKE, A. M. MCCARTHY, L.  
L. GLOVER, M. H. COLLIER, O. R. KLINE

Committee on Scientific Work: DRs. H. EYNON,  
Chairman; G. P. MEYER, V. MCDERMOTT

Nominating Delegate to State Society, DR. T. B.  
LEE

Members of Executive Committee: DRs. J. S. SHIP-  
MAN, two years; O. R. KLINE, three years; H. W.  
JACK, three years.

DR. HENRY B. DECKER presented the Historian's  
Report. He particularly stressed the function of  
the Society in relation to Civilian Defense Organi-  
zation and its cooperation with Procurement and  
Assignment Service.

LT. COL. L. R. WILSON, a member of the Society,  
gave a short informal talk outlining the present  
expansion program of the U. S. Army. He also told  
of his personal experiences in the service.

DR. WILLIAM HOFER, Williamstown, N. J., was ap-  
proved for active membership.

## ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

The 127th Annual Meeting of the *Essex County Medical Society* was held Thursday evening, May 14, 1942, at the Academy of Medicine, Newark, with a representative attendance. Several innovations were introduced by DR. FRANCIS C. WEBER, President, resulting in most interesting and stimulating meetings. They would well serve as an excellent example for the future.

Following the approval of the minutes of previous meetings of the Society and of the Council, a tribute was rendered to the members who died during the past year. Eleven chairs were draped in mourning and DR. HAROLD A. TARBELL read a brief biography of each doctor. This was followed by an eloquent and appropriate prayer by Fire Chaplain Rev. Oscar Braune.

The method of considering and approving committee reports was streamlined effectively. The complete reports have been published in the Bulletin of the Essex County Medical Society. This procedure allowed for their deliberate consideration by the whole membership prior to meetings and greatly accelerated action at the meetings. With few exceptions, the committee reports were accepted as published.

The Finance Committee's suggestion that the dues for 1943 be \$5.00 for the County Society, \$1.00 for the County Society Relief Fund, \$17.00 for the State Society, making a total of \$23.00, was approved.

DR. ROBERT H. ROGERS rendered the Treasurer's report.

DR. J. WALLACE HURFF offered a supplemental re-

port for the Economics Committee suggesting the following principles to safeguard the interests of those members who are serving with our armed forces:

1. The departing physician should notify his active patients and their families that he is entering the service and that Dr. X will care for his practice during his absence.

2. His records should be made available to the doctor caring for his practice.

3. The question of the percentage of money to be refunded should be decided by the parties concerned.

4. The physician taking over the doctor's practice is ethically obligated to inform patients that he is assuming responsibility for the duration of the war only; and to exert every effort to return those patients to the family physician upon his return to active practice.

5. The members of the County Society as a whole shall consider it their solemn duty to preserve and safeguard as far as possible the practices of men entering the service.

DR. WELLS P. EAGLETON made the suggestion, which was approved, that the Society accept as its wards for the duration of the war, the families of those medical men who are serving with the armed forces. DR. DAVID A. KRAKER pointed out that medical officers in the United States forces, being well paid, are adequately able to support their dependents; there is little likelihood of their families being in want.

It was announced that over 51 per cent of the Essex County physicians had agreed to cooperate with the Medical-Surgical Plan of New Jersey. This will make the Plan operative in Essex County.

DRs. GUY PAYNE and JEROME KAUFMAN served as tellers during the election of the following officers:

### Officers (1 year):

President, DR. WILLIAM W. COX  
President-elect, DR. J. WALLACE HURFF  
First Vice-President, DR. LOUIS SCHNEIDER  
Second Vice-President, DR. WILLIAM D. CRECCA  
Secretary, DR. MARCUS H. GRIEFINGER  
Treasurer, DR. ROBERT H. ROGERS  
Reporter, DR. EARL LEROY WOOD

Councilors (2 years): DRs. FRANK A. BIEN, Irvington; CLYMONT MACARTHUR, Newark; HAROLD A. MURRAY, Newark; ARTHUR W. WYKER, Bloomfield  
State Nominating Committee for 1943: Delegate, DR. H. ROY VAN NESS, Newark; Alternate, DR. WILLIAM H. ARESON, Montclair

Delegates to State Society (1943-1944-1945): DRs. E. H. ALBANO, East Orange; N. A. ANTONIUS, Newark; C. B. ANUARIO, Orange; GEORGE BLACKBURN, Newark; M. E. BROADNAX, Newark; W. D. CRECCA, Newark; MAX DANZIS, Newark; J. I. ECHIKSON, Newark; E. W. ERLER, South Orange; A. H. FRIEDRICH, Newark; W. H. HUBER, Maplewood; J. W. HURFF, Newark; B. A. O'CONNOR, Newark; H. B. ORTON, Newark; ERWIN REISSMAN, Newark; CHARLES RICH, Newark; C. M. ROBBINS, Newark; BENJAMIN SASLOW, Newark; R. A. SCHAAF, Newark; E. P. SCHAEFER, Irvington; JACOB W. SIEGEL, Newark; EDWIN STEINER, Newark; W.

A. TANSEY, Newark; H. A. TARBELL, Newark; H. R. VAN NESS, Newark; F. E. VOORHEES, Newark; A. C. ZEHNDER, Newark.

Alternates: Drs. W. A. ANTOPOL, Newark; C. A. BELING, Newark; SAMUEL BERG, Newark; W. A. BERGER, Newark; H. C. CROSSFIELD, South Orange; A. J. D'ALESSANDRO, Newark; A. F. DEPALMA, Newark; W. F. GRANT, Newark; S. Z. HAWKES, Newark; G. F. HEWSON, Newark; F. J. KERNS, Newark; JULIUS LEVY, Newark; L. H. LOESER, Newark; L. MANCUSI-UNGARO, Newark; F. J. MCCAULEY, Newark; D. W. MARQUIS, East Orange; J. F. MASTERTON, Irvington; G. A. MATHEKE, East Orange; E. L. MINARD, East Orange; JULIUS NEWMAN, Newark; G. A. PAUL, Irvington; A. L. REICH, Newark; S. D. REVERE, East Orange; FRANK ROCCO, Newark; C. A. SCHNEIDER, Newark; R. H. SCOTT, Newark; R. H. STAEHLE, Newark; J. E. TOYE, Arlington; W. K. WHEELER, Newark; F. P. WILLEY, Newark.

The following were elected members of the Society: Active, ROBERT BOZZI, Newark; NED SHAW, Kearny. Associate, LOUISE FISCHER, Newark; JOHN F. SCALERA, Newark.

Dr. Weber, in his presidential address, stressed the value of periodic health examinations in the field of preventive medicine. He pointed out the need of maintaining a maximum of health and efficiency during the war, saying: "Physicians are delinquent in their duty toward their country when they fail to advocate the periodic health examination as an outstanding method for the detection of disease trends and the prevention of unnecessary disease."

After citing figures to show the vast amount of physical impairment disclosed in examinations of large groups, including Army selectees, Dr. Weber continued: "The slowest to see the value of these examinations is the doctor himself. The private physician is more interested in the curative phase of medicine, allowing preventive medicine to slip into the hands of public health departments."

While the control of infectious disease is a joint problem of the private physician and the public health department, the treatment of degenerative diseases rightfully belongs to the practicing physician, the family doctor. One of his best means to discover early these diseases is the periodic health examination."

Dr. Weber pointed out that while medical groups have approved the examinations, it is up to the private physician himself to impress upon the public and his patients the need and value of these examinations and that he is the one best qualified to conduct them.

The family physician is best suited to make the periodic health examination because of the existence of that confidential and sympathetic relationship between patient and physician, so necessary to personal advice, in which physical and mental states, social and personal relations, domestic stresses which only the physician may hear, all appear as factors to be reckoned with. These relationships are inspired by mutual friendly interests and confidence and are founded upon a basis of

understanding. Here the personally selected private physician is at his best and of greatest service in adding to the quantity and quality of life.

He concluded: "To use the method of periodic health examination to full advantage requires the critical observation of a large group of persons over a long period of time. No one physician in his lifetime can expect to add more than a fragment of knowledge to all that can be obtained by the use of this method. Every physician, however, has an opportunity, as Sir William Osler said, to observe, record, tabulate, communicate. In this manner he has the chance to add bits of knowledge to the general fund of what is known of the clinical beginnings of the common causes of death."

Dr. Weber presented Dr. WILLIAM W. COX to the Society as its new President. Dr. Cox then awarded Dr. Weber the gold key of the Society as a symbol of the members' gratitude for his excellent service during past years, culminating in his presidential year during which he guided the Society with quiet, modest efficiency.

Dr. Cox made a plea for the general medical profession, especially the younger physicians, to take a more active part in the work of the County Medical Society, stating that too much is being done by too few. He said that he planned during the coming year to hold the County Society meetings jointly with other medical organizations, such as the Academy of Medicine and probably with organizations in the Oranges and Montclair.

Following the meeting the members adjourned to the social rooms in the adjoining Eagleton Medical-Civic House for a social period which was marked by conviviality and fellowship. A collation was served.

## HUDSON COUNTY

John N. Connell, Reporter

The regular meeting of the *Hudson County Medical Society* was held on April 6, 1942, at the Masonic Club, Jersey City, N. J. The meeting was called to order by PRESIDENT A. J. CONTY at 9:30 p. m.

Dr. Conty announced the death of Dr. PETER E. MARAS on Monday, April 6. DR. B. T. D. SCHWARZ spoke a few words in eulogy of Dr. Maras, as follows:

"I arise on a very sad occasion. One whose voice was often heard in these chambers—that voice has been stilled. Dr. Maras died suddenly from an attack of coronary thrombosis. It was characteristic of him to pass away suddenly, while working until the last minute. His entire medical career was one which many of us could well emulate. He worked hard and was a keen student. He prepared his work well. He was a real physician, he studied his cases thoroughly. Dr. Maras was a big fellow too, because despite his experience, despite his post-graduate work, he was always willing to learn more from his consultants. Those of us who have passed his office and saw his shingle, 'Dr. Peter E. Maras', with his office upstairs, we feel quite confident that it will always be thus—Dr. P. E. Maras, his office is Upstairs."

Members rose for one minute in silence.

Dr. Conty: "In reference to the report of the Executive Committee, there was an item pertaining to advertising in the 75th Diamond Anniversary Edition of the Jersey Journal, May 2, 1942. This was discussed in detail by the Executive Committee and they decided that it would be good policy to take a space in this issue and that the advertisement be placed under the guidance and supervision of the Publicity Committee." This action was approved.

DR. GEORGE P. MULLER, Professor of Surgery, Jefferson Medical College, Philadelphia; former President of the American College of Surgeons, spoke on "Carcinoma of the Stomach".

Discussors were DRs. BARBARITO, E. HALLIGAN and GLEESON.

DR. NORMAN M. SCOTT, Secretary Physicians' Division, New Jersey Procurement and Assignment Service, spoke on "Procurement and Assignment as It Relates to the Physician". A general discussion followed.

The following were elected to serve on the Nominating Committee in 1943: DRs. J. L. EVANS, E. M. KIELY, E. J. DALY, J. A. BOTTI, C. J. LARKEY.

The State Society notified the County Society that we were entitled to three more Delegates. The following names were selected: DR. JOHN J. BROZDOWSKI, 2 years to 1944; DR. JOSEPH P. DONNELLY, 2 years to 1944; DR. NICHOLAS M. ALTER, 2 years to 1944 in place of the late Dr. William T. Callery.

DR. H. ALBERT SCALA of Jersey City was elected to membership.

DR. J. F. LONDRIGAN announced that the Board of Trustees of the State Society held a meeting in Trenton, March 22, 1942, attended by DR. J. F. NORTON and himself. There had to be a change in the Medical Service Administration Plan and it is now known as the Medical Surgical Plan.

Dr. Londrigan moved that we approve the action of the Board of Trustees in recommending the adoption by the Hudson County Medical Society of the Medical Surgical Plan of New Jersey.

## MIDDLESEX COUNTY

Cyril I. Hutner, M.D., Reporter

The *Middlesex County Medical Society* meeting was held on Thursday, April 16, 1942, at the Roosevelt Hospital, Metuchen. DR. MATTHEW F. URBANSKI presided. The minutes of the previous meeting were accepted as read.

The Associate Members voted in as Regular Members were:

DR. LEON TISCH, Piscatawaytown

DR. STANLEY A. GADEK, Perth Amboy

DR. OSCAR J. SOKOLOFF, New Brunswick

DR. F. M. HOFFMAN, Chairman of the Blood Bank Committee, suggests that the Society ask the Board of Freeholders to take over the problem and to form a bank in a centrally located hospital in the county.

DR. J. J. MANN, Chairman of the Public Relations Committee, reported favorably on the druggists' plan of having uniform prescription blanks.

## MEDICAL SURGICAL PLAN

Resolution proposed by the Public Relations Committee:

"Be It Resolved, That the Middlesex County Medical Society, in meeting assembled, declines to participate in the Medical-Surgical Plan of New Jersey."

Seventy-four members of the Society voted against the Medical-Surgical Plan of New Jersey. There were no votes in favor of it.

DR. SIMON KLOSKY of the Gas Defense Committee of New Brunswick gave a very enlightening talk on war gases.

The meeting was then adjourned and refreshments were served in the cafeteria.

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday, May 20, 1942, at the Roosevelt Hospital, Metuchen, N. J., with PRESIDENT M. F. URBANSKI in the chair.

DR. HUTNER, Chairman of the Arrangements Committee, reported that the outing with the dentists will take place on June 17 at the Jumping Brook Country Club. Dinner will be \$2.50 and golf \$1.00. Cocktails will be served and an outstanding speaker will address the gathering at dinner. Dinner reservation cards will be sent to all the members.

DR. I. COOPER of New Brunswick is entering the Public Health Service on May 26. A certificate will be given to him stating that he is in good standing with the Society.

DR. SAMUEL FOMON of New York City spoke on "Useful Reconstructive Plastic Surgery."

Refreshments were served in the cafeteria.

The June meeting of the *Middlesex County Medical Society* was held on Wednesday, June 17, 1942, at Oak Hills, Metuchen, N. J. This meeting was the second annual outing of the doctors and dentists of Middlesex County. The afternoon was devoted to golf at the Metuchen Golf and Country Club and dinner was served in the evening at Oak Hills Manor. The speaker of the evening was MAJOR HAROLD G. HOFFMAN of the U. S. Naval Air Force.

At the conclusion of his speech, Major Hoffman was made an Honorary Member of the combined Medical and Dental Societies.

## MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held on May 27, 1942, at 9:00 p.m. at the New Jersey State Hospital, Marlboro, N. J. DR. MOFFAT presided. The election of officers was held with the following results:

DR. KAZMANN became President automatically, as he was President-Elect last year.

President-Elect, DR. L. L. LEONARD

Secretary-Treasurer, DR. L. F. ALBRIGHT

Assistant Secretary-Treasurer, DR. K. F. METZGER

Reporter, DR. MURRAY WORONOFF

Executive Committee: DRs. O. K. PARRY, OTTO R.

HOLTERS, H. R. BRINDLE



Board of Censors: Drs. S. W. HAUSMAN, H. B. MASON

Delegates to State Society: Drs. D. F. FEATHERSTON, T. E. FENTON, G. G. REYNOLDS, R. E. WATKINS, O. R. HOLTERS, C. B. BLAISDELL

Nominating Delegate, Dr. D. F. FEATHERSTON

Alternates: Drs. R. McTAGUE, D. V. MANAHAN, WILLIAM MATTHEWS, J. E. JORDAN, J. C. CLARK, H. A. KAZMANN

The meeting was turned over to Dr. BERKELEY GORDON, Director of the N. J. State Hospital, who presided over the scientific part of the program and introduced the speakers. They were:

Dr. ZYGMUNT A. PIOTROWSKI on "The Rorschach Method of Personality Analysis".

Lt. Commander JAMES B. PETTIS, M.C., U.S.M., on "The Effect of War on the Mental Health of the Civilian Population".

Both talks were well received.

Refreshments were served after the talks.

### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

Dr. HAROLD S. HATCH was the host at the May meeting held Thursday evening, May 21, 1942, at Shonghum Mountain Sanatorium, which was well attended.

PRESIDENT TELLER announced the Annual Dinner Meeting to be held Thursday, June 18, 1942, at the Spring Brook Country Club, Morristown, at 7:30 p. m.

Dr. Hatch introduced GRANT THORBURN, M.D., F.A.C.P., Associate Physician, Tuberculosis, Lenox Hill Hospital, New York City; Consulting Physician, Municipal Sanatorium, Otisville, New York; Consultant at Summit Park, Pomona, and Morristown Memorial Hospitals, whose topic was "The Pre-symptom Diagnosis of Pulmonary Tuberculosis". He indicated the importance of recognition of the disease in the minimal stage, before pulmonary tissue change can cause gross signs, as treatment at this time, such as collapse therapy, is more certain of favorable results, and thus avoiding more radical treatment later on. The presence or absence of positive sputum is of great prognostic significance. The vast majority of cases of pleurisy with effusion are found to have the tubercle bacillus present and a large percentage of these individuals are living and well after adequate treatment and avoid the development of cavities. Dr. Thorburn stressed the necessity of the use of x-ray in screening out early lung abnormalities and mentioned the difficulty in discovering minimal lesions because it is so prone to be asymptomatic. He stated that the vast majority of adult tuberculosis is the endogenous reinfection from an old focus. The speaker stressed the importance of careful check-ups and examinations of individuals after respiratory illness, and gave some interesting statistics on the large number of nurses and medical students entering training with negative Mantoux tests and ending up with a positive. We were shown a number of slides and chest films illustrating various lesions discussed.

In the discussion Dr. Hatch brought out the fact

that a lot of early cases do not go to a doctor, and that there are others almost explosive in character, and that there is an allergic factor especially in post partum cases. Dr. Douglas emphasized the need for chest x-rays on contacts even without symptoms.

Gold, Dinner, Business and Fellowship were subjects on the program for the Annual Dinner Meeting of the *Morris County Medical Society* Thursday, June 18, 1942, at the Spring Brook Country Club, Morristown. In addition to our members there were many distinguished guests including President ELIAS J. MARSH, First Vice-President JOSEPH F. LONDRIGAN, NORMAN M. SCOTT and JAMES F. NORTON of the State Society.

Dr. TELLER, the retiring President, conducted the business meeting which followed the presentation of the prizes to the many winners in the golf tournament. The list of names to whom prizes, which included a variety of useful medical accessories, were awarded, is too long to record in this report.

The following officers for the year 1942-1943 were elected:

President, F. CLYDE BOWERS  
Vice-President, D. J. GEARY  
Secretary, G. J. YOUNG  
Treasurer, J. H. HARRINGTON  
Reporter, W. M. JUDD  
Historian, G. H. LATHROPE

The following members were added to the Executive Committee: J. A. BYRNE, M. T. RYMAN, A. P. KING.

Three Delegates to serve at the State Convention for a three-year term were elected: B. C. McMAHON, H. VONDEILEN, A. O. HUBERT.

The eight Alternate Delegates to serve at the State Convention elected were: C. A. MUSETTO, J. F. JOHNSTON, E. McELROY, A. W. VANSICKLE, W. G. TALMAGE, F. A. WADE, B. G. SHERMAN, E. T. CARRBERRY.

Delegate to the State Nominating Committee is B. C. McMAHON; Alternate, B. G. SHERMAN.

Dr. McMAHON was especially commended for his able work as Chairman of the Medical Preparedness Committee, as was Dr. RUTH EARP, who again promoted an excellent Post-Graduate Education program. Dr. I. F. FROST was commended for his Maternal Welfare program. Dr. Teller expressed appreciation to the many other physicians and committees who faithfully fulfilled their duties and to Dr. CURRY, Chief Executive Officer of the New Jersey State Hospital at Greystone Park, and to Dr. HATCH, Director of the Shonghum Tuberculosis Sanatorium, who have served as hosts for meetings during the past year.

Our new President, Dr. F. CLYDE BOWERS, was introduced and indicated his intention of continuing an active program for the next year.

There was some discussion concerning the licensing of osteopaths to practice medicine, and on the dictation of the American College of Surgeons among the hospitals. Dr. Marsh, President of the State Society, in his discussion made it plain that such problems will be ably managed during his administration. It was decided to refer these mat-

ters to the Executive Committee for study; the report to be made at the first fall meeting.

Our guest speaker, DR. CHARLES H. SCHLICHTER, New Jersey representative of the Procurement and Assignment Agency and Chairman of Committee on Medical Preparedness and on the State Defense Council, presented as his topic "Procurement and Assignment". He reviewed the background of the setup for medical preparedness in which an inventory of the national scientific and medical power has been made by means of the questionnaire. There are three elements in the relation of the medical profession to the war effort: (1) The Selective Service Organization, (2) the relationship with the N. J. Defense Council and (3) the relationship with Emergency Medical Service.

Procurement and Assignment is an unofficial organization without official authority, functioning as a liaison committee and in an advisory capacity. It is guiding in the distribution of physicians in civilian communities. The speaker went into some detail concerning the great demand for large numbers of physicians who are needed between now and December 31, 1942, and indicated that steps will probably be taken to grant citizenship to friendly aliens, thus making them available as medical officers, if their schools measure up to our Class A requirements. This plan is subject to the approval of the Surgeon General.

Dr. Schlichter emphasizes the urgent need of doctors under the age of 37 for assignment to duty with troops, in order to keep them well and on duty. Our members were warned that as a profession and as individuals we are bound to make sacrifices, and our coöperation with Procurement and Assignment is an obligation of the medical profession.

DR. SCOTT in his discussion reëmphasized the needs of the Armed Services and made it plain that coöperation is a "must".

## PASSAIC COUNTY

### I. Okin, M.D., Reporter

Honored by the presence of the President of The Medical Society of New Jersey, DR. ELIAS J. MARSH, the last meeting of the year was held on Thursday, May 14th, 1942, at 9:00 p. m. at the Paterson Health Center. DR. SIGURD W. JOHNSEN presided.

The following resolution on the death of DR. GEORGE E. TUERS was read:

"Whereas, The members of the Passaic County Medical Society feel a sincere and profound regret in the passing of Dr. George Edward Tuers, and

"Whereas, For more than forty years, he practiced his profession faithfully, honorably and with a sympathetic understanding that won him enduring admiration. Always giving unstintingly of his time and energy on behalf of the ill; his wisdom, unselfish generosity in all things charitable, his integrity and his sincere fidelity, made him loved by all his fellow men. A stalwart man, a man of courage. For many years he was Chief Anesthetist in the Paterson General Hospital. His wisdom and council were often sought at that institution where he served as President of the Medical Board from

1930 to 1932. He was long an active leader in the Passaic County Medical Society, contributing willingly of his time and effort. He served as President of the Society in 1928.

"Whereas, The Divine Creator, in His Infinite Wisdom, has seen fit to call unto Himself our respected colleague and friend, we request that the Passaic County Medical Society adopt the following resolution:

"Be It Resolved: That the members of the Passaic County Medical Society deeply mourn the loss of our late colleague, Dr. George Edward Tuers, and express our heartfelt sympathy to his daughters, Mrs. Gilbert H. Jeffrey and Miss Louise Tuers, and

"Be It Further Resolved: That this resolution be spread in full upon the minutes of this meeting and a suitable copy thereof be presented to his family.

"(Signed) JOSEPH A. MACLAY, M.D.  
W. W. MACALISTER, M.D.  
JOSEPH E. MOTT, M.D."

Dr. Marsh also gave a personal eulogy of Dr. Tuers.

The Nominating Committee for the officers of the Society presented the following candidates who were elected:

President, THOMAS A. CLAY  
First Vice-President, CHARLES J. MURN  
Second Vice-President, HARRY WOLFSON  
Secretary, J. ALLEN YAGER  
Treasurer, THEODORE K. GRAHAM  
Reporter, IRVING OKIN

Member of the Board of Censors (3 years): SIGURD W. JOHNSEN

The following physicians were elected: Active membership, DRs. D. K. KLUGHAUPT of Passaic, DAVID LEVY and DAVID SHAPIRO of Paterson. Associate membership, DRs. JAMES P. MORRILL, Jr., and C. MAZZARELLI of Paterson.

Two applications for membership were received. Committee Annual Reports were printed in the May issue of the Bulletin.

Dr. Marsh was introduced to the audience and mentioned the honor bestowed on the Passaic County Medical Society in the appointment of DR. JOSEPH E. MOTT to the Publication Committee of the State Society, as a tribute to his fine work on our County Society Bulletin.

DR. LEOPOLD E. THRON, co-editor of the Bulletin, has been appointed a member of the Public Relations Committee of the State Society.

Dr. Johnsen advised that twenty signatures were yet needed for the Medical-Surgical Plan and he hoped that the members would sign up soon so that the plan could get started in Passaic County.

DR. GEORGE F. HOCH, Associate Attending Urologist at St. Luke's Hospital, New York City, was introduced by Dr. Sidney Levine. Dr. Hoch gave a comprehensive survey of the treatment of urinary tract infections. He discussed the surgery of the tract and said any general practitioner could treat urinary infection and in fact was doing it, but when an infection did not clear up in a reasonable length of time, a complete urographic study should be made. The general care of the patient and the

forcing of fluids are very important. Sulphadiazine is the best drug in urinary infections and causes less toxic symptoms than the other preparations. Large doses are not necessary but in large doses sulphadiazine as well as sulphapyridine and sulphathiazole may cause crystalization in the urine.

The paper was discussed by DRs. SIDNEY LEVINE, RALPH C. YEAW, SAUL PEARLMAN and O. H. CLARK.

The new President, DR. THOMAS A. CLAY, asked for the coöperation of all members and gave his promise to do his best for the Society. He stated he was open to suggestions for improvements in the meetings and the activities.

Dr. Johnsen concluded a very successful and effective year as President. His energy, decisiveness and leadership have been a model for future Presidents. The Passaic County Medical Society has been fortunate in his leadership and looks forward to further stimulating leadership under President Thomas A. Clay.

The meeting then adjourned.

### SOMERSET COUNTY

Lancelot Ely, M.D., Reporter

The regular and Annual Meeting of the *Somerset County Medical Society* was held at the Nurses' Home on June 18, 1942. The usual routine of business was transacted.

The annual election of officers resulted as follows:

President, DR. DONALD O. HAMBLIN  
Vice-President, DR. FRANK L. FIELD  
Secretary, DR. ARTHUR F. MANGELSDORF  
Treasurer, DR. ALBERT W. PIGOTT  
Reporter, DR. LANCELOT ELY

Delegate to the State Society, DR. GEORGE E. BARBOUR

Alternate to the State Society, DR. RUNKLE F. HEGEMAN

Delegate to the Nominating Committee of the State Society, DR. LEWIS C. FRITTS

### SUMMIT MEDICAL SOCIETY

Elwood H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held on Tuesday evening, May 26th, at the Canfield Tea Room.

DR. STEUART, the President, presided. There were thirty members and eight guests present.

DR. THOMAS M. DURANT, Professor of Medicine at Temple University in Philadelphia, gave a very interesting lecture on "Diagnostic and Therapeutic Problems in Acute Pulmonary Disease". This was followed by a general discussion.

Following the meeting a collation was served.

## WOMAN'S AUXILIARY

### Camden County

Reported by Mrs. E. Reed Hirst

The *Woman's Auxiliary to the Camden County Medical Society* held their Annual Luncheon and Meeting on Tuesday, May 5, at the home of Mrs. Irvin E. Deibert, "The Larches", in Edgewater Park.

Following the luncheon the meeting opened at 2:30 p. m. with the President, Mrs. George B. German, in charge.

After greeting all members and guests (85), Mrs. German presented the Program Chairman, Mrs. Henry R. Tatem, Jr., who in turn introduced the guest speaker, Dr. John A. Bornemann, Professor of Pharmacy at Hahnemann Medical College. Dr. Bornemann gave a most interesting talk on "War, and Its Effect on Our Well-Known Drugs". He also exhibited specimens of plants from which the drugs are made.

Mrs. German thanked all the officers and members for their coöperation and help. The Treasurer's report was read and approved. It was agreed that other reports be dispensed with.

Mrs. A. Haines Lippincott, a past county and also a past State President of the Auxiliary, presented Mrs. German with the President's Pin, and a vase filled with red roses, from the Auxiliary.

Mrs. Tatem then presented Mrs. Everett Clark, who sang three selections, accompanied by Mrs. Amos Shirley at the piano.

Mrs. German turned over the gavel to Mrs. Tatem, the new 1942-43 President of the Auxiliary, who expressed her gratitude for the honor and announced the committee chairmen for the coming year.

There being no further business, the members and guests enjoyed a tour of the grounds, looking at flowering shrubs, trees and the beautiful scenery.

## INTOLERANCE TO DIETHYLSTILBESTROL

Nausea and vomiting have been the most frequent side-effects following administration of Stilbestrol (diethylstilbestrol). A recent report (J. A. M. A., 119:400, May 30, 1942) points out that there is a definite relation between these symptoms and the nausea and vomiting of early pregnancy. If one will merely take the time to ask the prospec-

tive patient if she had nausea and vomiting with a previous pregnancy, it would serve as a warning to give not over 0.25 mg. daily as an initial dose. Desensitization may be accomplished by giving 0.1 mg. tablets once daily for five days, then increasing the dose gradually until the therapeutic level is reached.



## BOOKS RECEIVED FOR REVIEW

**DISABILITY EVALUATION;** principles of treatment of compensable injuries. By Earl D. McBride, B.S., M.D., F.A.C.S. 3d ed. Philadelphia, The J. B. Lippincott Company. 1942. \$9.00.

**MEDICAL APPLICATIONS OF THE SHORT WAVE CURRENT.** By William Bierman, M.D. With a chapter on physical and technical aspects. By Myron M. Schwarzschild, M.A. 2d ed. Baltimore, Wm. Wood & Co., 1942. \$5.00.

**UROLOGY IN WAR;** wounds and other emergencies of the genito-urinary organs surgical and medical. By Charles Y. Bidgood, Lt. Comdr. (M.C.), U. S. N. R. Baltimore, Williams & Wilkins. 1942. \$2.00.

**HEALTH EDUCATION OF THE PUBLIC;** a practical manual of technic. By W. W. Bauer, B.S., M.D., and Thomas G. Hull, Ph.D. 2d ed. Philadelphia, W. B. Saunders Company. 1942. \$2.75.

**SEROLOGY IN SYPHILIS CONTROL;** principles of sensitivity and specificity, with an appendix for health officers and industrial physicians. By Reuben L. Kahn, M.S., D.Sc. Baltimore, Williams & Wilkins Company. 1942. \$3.00.

**COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION.** Ed. by Richard M. Hewett, B.A., M.A., M.D.; A. B. Nevling, M.D.; John R. Miner, B.A. Sc.D.; James R. Eckman, A.B., and Katharine Smith, B.A. v. 33. Philadelphia, W. B. Saunders Company. 1942. \$11.50.

**BLOOD GROUPING TECHNIC;** a manual for clinicians, serologists, anthropologists and students of legal and military medicine. By Fritz Schiff, M.D., and William C. Boyd, Ph.D., with a foreword by Karl Landsteiner. Pp. 248. New York, Interscience Publishers, Inc. 1942. \$5.00.

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## BOOK REVIEWS

**Play for Convalescent Children in Hospitals and at Home.** By Anne Marie Smith. Pp. 133. New York, A. S. Barnes & Co. 1941. \$1.60.

There is a very real need for this kind of training in the care of convalescent children. This book is an excellent example of what can be done. It should also prove useful for those dealing with occupational therapy among the mentally deficient, and of unsound minds of adult years.

VERA B. FLOYD.

**Synopsis of Applied Pathological Chemistry.** By Jerome E. Andes, M.D., and A. G. Eaton, B.S. St. Louis, C. V. Mosby Company. 1941. \$4.00.

This book is intended as a light text on the subject of pathological chemistry as applied to clinical medicine, and will be a handy reference book for practitioners who need to review this subject.

Its arrangement of proceeding is at first explanatory followed by more detail. The tables are excellent and their compilation is a valuable aid to the student and operator, and together with the illustrations, should prove useful to the various workers in the fields of medicine and chemistry.

ALBERT E. EDEL.

**Diseases of Women.** By Harry Sturgeon Crossen, M.D., F.A.C.S., and Robert James Crossen, A.B., M.D. 9th ed. Pp. 948. St. Louis, C. V. Mosby Company. 1941. \$12.50.

Seldom does a revised textbook come to us with such a profusion of new material as the ninth edition of "Diseases of Women" by Crossen and Crossen. During the past decade the science of gynecology was in such state of flux that monographs and texts in this field were antiquated even before the print dried. This splendid new edition of a great text, however, was perfectly timed. All the recent advances in gynecologic diagnosis and

treatment are herein contained. The physiology is presented so clearly that the lowliest neophyte may interpret it easily. The newer endocrinology is complete. The chapter entitled "Gynecologic Treatment Measures" alone is worth the price of the volume. Vitamins, endocrines—the table of "Standardized Hormone Preparations" makes excellent reference material—plasma transfusion and even refrigeration therapy are all given detailed consideration. Many new illustrations, a great number of them colored, have been added to a text already pictorially rich. With all this the best of the old Crossen, such as "Medico-Legal Points in Gynecology", has been retained.

Certainly no reference library of gynecologic knowledge can be complete without this new edition of an old classic.

GERALD HAYES.

**1941 Year Book of Obstetrics and Gynecology.** Ed. by Joseph B. DeLee, A.M., M.D., and J. P. Greenhill, B.S., M.D., F.A.C.S. Pp. 704. Chicago, Year Book Publishers, Inc. 1942. \$3.00.

As usual, the Year Book has picked out the high spots in the current articles of the year. It is divided into two parts, the Obstetrical Section reviewed by Dr. DeLee, and that on Gynecology by Dr. Greenhill.

The editorial comments are always most interesting and illuminating, bringing to our attention the high spots and fallacies in the articles reviewed.

The material included in the Year Book is extensive, and it would be futile to attempt to review all of the material covered. Of particular note, however, is the description of the Scanzoni Maneuver by Dr. R. J. Picri, published in the New York Journal of Medicine, December 15, 1940, and ably reviewed with illustrations in the Year Book.

The Pomeroy manual rotation is also abstracted, and well described as used in posterior position of the presenting head for many years at the Brook-

lyn Hospital. The section on the new-born brings out many new and interesting observations as gleaned from the most interesting articles of the year.

Gynecology was reviewed in the literature by Dr. Greenhill and abstracts were made of articles on many new and novel operations. The editorial comments are of real value and interest. Treatment of pelvic infections by the sulpha group of drugs is well reviewed. New facts on menstruation and its disorders are described with a wealth of good illustrations. A discussion of endocrinology takes up a great deal of space in the book, probably more than actual facts would warrant.

All in all, the book serves its purpose as a handy guide, and a stimulus to further reading on articles that may be of interest.

ALFRED MEURLIN.

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**Textbook of Surgery by American Authors.** Edited by Frederick Christopher, B.S., M.D., F.A.C.S. 3d ed. Pp. 1764. Philadelphia, W. B. Saunders Co. 1942. \$10.00.

The third edition of Frederick Christopher's Textbook of Surgery is as welcome as the first and continues to hold its place with the foremost surgical treatises in English. The new edition embraces recent developments in sulfonamide therapy, as well as extensive revisions in chapters relating to the spleen, the rectum, gastric ulcer, and other conditions.

While a 1942 textbook would probably not be considered complete without some mention of war injuries, the reviewer wonders, as undoubtedly the editor did, how such information can be best presented. The devotion of less than ten pages to war injuries, in a book of over 1750 pages, would seem to be inadequate.

This is a large volume full of many things of interest to both student and practitioner.

C. ABBOTT BELING.

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**Methods of Treatment in Postencephalitic Parkinsonism.** By Henry D. von Witzleben. Preface by Theodore J. C. von Storch. Pp. 164. New York, Grune & Stratton. 1942. \$2.75.

Dr. von Witzleben's monograph of 164 pages is a carefully prepared succinct statement of the facts presently known of the various treatments that have been used for the alleviation of the tragic sequelae of epidemic encephalitis.

Except for some slight errors, the book is extremely well written. One wonders, for example, at the age of Tracy Putnam. The author says: "Since Parkinson, in his first paper (1817), described the disappearance of the tremor if the patient develops an apoplexia, i.e., a lesion of the corticospinal tract, Putnam then tried section of the pyramidal tract."

Dr. von Storch's introduction sets forth very well the value of the book: "The present mono-

graph should be of much value to student, practitioner and specialist. The author has made a comprehensive review of the numerous therapies that have been recommended, with a brief evaluation of each." We agree with him that each patient remains an individual problem, even after an accurate differential diagnosis has been made. "Thoughtless application of various recommendations by the author may result in much disappointment." Those who have treated these unfortunates know this only too well.

We recommend this valuable little monograph to all who desire to know about the care and treatment of patients suffering from the sequelae of epidemic encephalitis.

CHRISTOPHER C. BELING, M.D.

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**Preëclamptic and Eclamptic Toxemia of Pregnancy.** By Lewis Dexter, A.B., M.D., and Soma Weiss, A.B., M.D., in collaboration with Florence W. Haynes, Herbert S. Sise and James V. Warren. Pp. 415. Boston, Little, Brown & Company. 1941. \$5.00.

In this monograph the authors have studied eighty toxic cases of pregnancy and reviewed the literature in a thorough way. The different phases of toxemia have been taken up by chapters with a comprehensive conclusion both as to their own cases and those in the recent literature. The final chapter on treatment is especially detailed and comprehensive.

The untimely death of Dr. Weiss, since the book was published, is a great loss to the profession, and lends an added interest to this, his last contribution to obstetrics.

Every obstetrician, as well as those in other branches of medicine, will find this book of valuable interest; the conclusions at the ends of each chapter, at least, should be read by all.

CARL H. ILL, M.D.

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**Textbook of Clinical Parasitology.** By David L. Belding, M.D., Pp. 888. New York, D. Appleton-Century Company. 1942. \$8.50.

At this time when war is spreading parasitic and tropical disease throughout the land, a one-volume, comprehensive text on parasitic disease is a most welcome addition to the medical literature. The reviewer has in his library all of the English and American publications on parasitology which have been published in recent years. None will be more helpful to the physician who wishes to purchase one book on the subject than Belding. The book is sturdily bound. Excellent paper stock is used. The illustrations are clear and adequate. There is a separate handy section on technical methods for the diagnosis and treatment of parasitic infestations. This section is brief, to the point, and makes a most valuable addition to the book.

MANFRED KRAEMER, M.D.

# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

July, 1942

No. 7

AS mills and factories hum, as thousands of men and women swell the ranks of labor under the pressure of war industry, problems concerning the health of workers are in danger of being pushed aside. Tuberculosis is one of the notorious wasters of manpower. Special attention must be given to this disease as it affects, and is affected by, occupation. To help clarify concepts, a symposium on tuberculosis in industry was held at the Saranac Laboratory where leaders in health and industry discussed problems which will also interest the general practitioner. A resumé of the symposium follows:

### TUBERCULOSIS IN INDUSTRY

The prevalence of tuberculosis in any community is determined by the general standard of living and by the number of open carriers. In particular occupations the factors of selective employment and unfavorable environment modify the picture. If such factors, work involving silica, for example, are dominant, the incidence in the wage earners will be different from that of their families.

The source of the great bulk of infections is a human carrier with a pulmonary cavity. While the home is probably the place of most childhood and some adult contacts, many primary infections and more reinfections must occur in the place of work. Nurses, physicians and attendants on the sick encounter a real occupational hazard from infection itself and this hazard should be accepted as incidental to the professional life while hospital management should assume the obligation of minimizing opportunities for mass infection.

About 65% more young women than men die of tuberculosis between the ages of 15 and 25. From a practical standpoint the employer of large numbers of women needs an effective medical department if he would avoid a tuberculosis problem. Race is a factor to be considered but it is so intricately associated with the effects of living standards and environment that its effects cannot be weighed. Nutrition is another important factor but also one of the most difficult to evaluate. The influence of fatigue has been studied in the automobile industry and in a steel mill and in neither case was there evidence to suggest that this factor

was responsible for any excess of tuberculosis. The belief that abnormal degrees of temperature and humidity lower resistance has little to support it. Trauma does not initiate a primary infection of the lungs.

Tuberculosis has been regarded as the great enemy of the printer (printers and painters have about 16% more tuberculosis than all occupied males) and in turn was attributed to lead poisoning which printers might have contracted. Certain studies indicate that neither lead absorption nor lead intoxication is the cause of excess tuberculosis among lead and zinc workers.

Fumes and gases are inhalable and many of them are sufficiently irritating to provoke severe inflammatory reaction. Mature judgment on the effects of gas used by the armies during the last war reversed the early opinion that this agent was responsible for the excess of tuberculosis that developed. Routine annual examination of a large group of employees engaged in the manufacture of chlorine, phosgene, hydrofluoric acid and other irritating gases, supports the view that exposure to irritant gases is not responsible for excess tuberculosis.

The general thesis that inflammation of the lungs is necessarily unfavorable to the course of associated tuberculosis has little support. It is probably true that certain kinds of inflammatory reactions may have some influence. The increased incidence of tuberculosis that followed epidemic influenza may have been due in part to pneumonic complications.



In grain handlers exposed to high concentrations of organic dust in unloading lake steamers, 2.5% of a group of 234 showed X-ray evidence of clinically significant tuberculosis and another 2.3% had old healed lesions. Social-economic factors rather than grain dust were thought to be responsible. Tobacco dust has been under suspicion as a cause of tuberculosis since Ramazzini's time in 1700. Yet, in a modern cigar factory with a well organized medical service and air conditioned rooms there was less tuberculosis than in the city where the plant was located. Metropolitan mortality figures for 1937-39 show an index for tuberculosis of 107 in cigar and tobacco factory operatives but it should be noted that 75% of the labor, which now produces only 25% of the product still works in small shops without health supervision.

Low rates for tuberculosis were found in the Saranac Laboratory studies of the cement and gypsum industries. The usual amount of healed infection was disclosed, so that opportunities for infections had not been lacking.

All these observations support the view that exposure to organic and nonsiliceous dusts has little influence on susceptibility to tuberculosis. Reports on foundries, quartz mining and the granite industry brought out that higher tuberculosis rates prevail in these trades, that there is a greater tendency for such infection to develop after the age of 40 rather than earlier and that the infection is extremely chronic, often giving no symptoms of intoxication or a positive sputum until shortly before death. In miners the incidence becomes higher and the prognosis of associated tuberculosis worse as the silicotic reaction increases. Miners exposed to silica dust with no roentgenographic evidence of reaction showed little more tuberculosis than the community in which they lived. Foundries seem to be responsible for the least amount of tuberculosis, while the

granite industry showed that it probably caused the most.

Vermont marble workers had two and one-half times as much tuberculosis as the general population of the state (largely rural) exclusive of the granite center in Barre. By contrast, the rate for granite workers was 130 times the general one.

The value of a good industrial hygiene program was brought out by the experience of the Eastman Kodak plant. This program costs \$10,500 annually, but it also costs \$3,218 to treat one minimal case of tuberculosis. The attack rate in this plant has fallen from 2.3 at the outset of a study to 0.2 at the present time.

The complexities of compensation insurance carriers were discussed. One plan proposed was that evidence of tuberculosis in any form should preclude employment in industries with silica or other proved hazards and that compensation should be allowed for all tuberculosis subsequently developing in such employment. In other industries, with no specific hazards, persons with healed tuberculosis should be permitted to work but no compensation should be allowed for infections that might become active or develop during employment. In view of the evidence that old tuberculosis so rarely breaks down in any industry except industries with silica hazards, this would appear most equitable.

In the summary it was pointed out that, aside from nutrition and social-economic factors, silica is the only other one which has a recognized effect on susceptibility to tuberculosis. Many industrial conditions popularly accepted as predisposing to this disease are without measurable effect.

*A Symposium on Tuberculosis in Industry Held at the Saranac Laboratory, Saranac Lake, New York, in June 1941: A Resumé. Journal of Amer. Med. Assn., Feb. 21, 1942.*

"Tuberculosis in Industry," a paper-bound volume of 374 pages, with fifty charts and illustrations, is a complete symposium contributed by twenty-eight industrial hygienists at Saranac Lake, June, 1941. It may be obtained from any local or state tuberculosis association or the National Tuberculosis Association, 1790 Broadway, New York, N. Y. Price on request.

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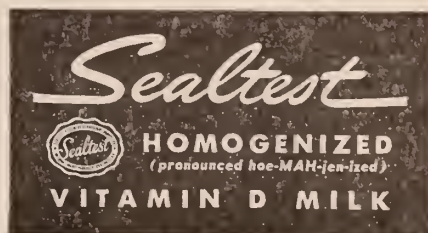
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### CONTENTS—Pages 415-464

#### EDITORIALS—

THE ANNUAL MEETING TRANSACTIONS	415
THE PEST	416
SKELETONS	417
NEONATAL DEATHS IN NEW JERSEY IN 1940	417

#### THE WAR—

Less Neuroses in Wartime	418
First Aid Dressing	418

#### ORIGINAL ARTICLES—

EPIDEMIOLOGY IN WAR TIME—Joseph A. Bell, Passed Assistant Surgeon, Bethesda, Md.	419
EARLY DIURESIS IN CONGESTIVE HEART FAILURE —Clarence L. Andrews, M.D., F.A.C.P., At- lantic City, N. J.	424
ABDOMINAL PAIN OF UROLOGIC ORIGIN IN CHILDREN— Meredith F. Campbell, M.D., New York, N. Y.	427
SYPHILIS OF THE NOSE AND MOUTH—Oram R. Kline, M.D., Camden, N. J.	432
OSTEOMYELITIS OF SKULL—Raphael Pomeranz, M.D., Newark, N. J.	436
ANGINAL PAIN DUE TO ADHESIVE PERICARDITIS— Louis A. Eigen, M.D., and Arthur R. Aby, M.D., West Orange, N. J.	439
CASE OF "ARGYRIA" IN YOUNG FEMALE DUE TO OVERADMINISTRATION OF A COLLOIDAL SILVER PREPARATION— Milton H. Gordon, M.D., Camden, N. J.	441

#### ORIGINAL ARTICLES—Continued—

FACT, FUNCTIONAL OR FAKE—The Neuropsychiatric Problem of the Army—Major James A. Brussel, Fort Dix, N. J.	442
RUPTURE OF THE UTERUS—A STUDY BASED ON MATERNAL DEATHS IN THE STATE OF NEW JERSEY, 1937-1941. Maternal Welfare Article No. 72—Robert R. White, M.D., F.A.C.S., East Orange, N. J.	446
A LESSON FROM A DEATH CERTIFICATE—No. 43	449

#### STATE ACTIVITIES—

Industrial Medicine—James M. Carlisle, M.D.	450
1942 Annual Meeting of the House of Delegates, Executive Officer's Abstract	451
The Jefferson Medical College of Philadelphia, 117th Annual Commencement	452
Members Serving in the Armed Forces	453
Supplementary List of Members	454
Restricted Coverage in Malpractice Actions	454
Procedure in Procurement and Assignment	454
Aims and Activities of the State Department of Health—J. Lynn Mahaffey, M.D.	455

#### OBITUARIES

#### BULLETIN BOARD

#### THE BOOK SHELF

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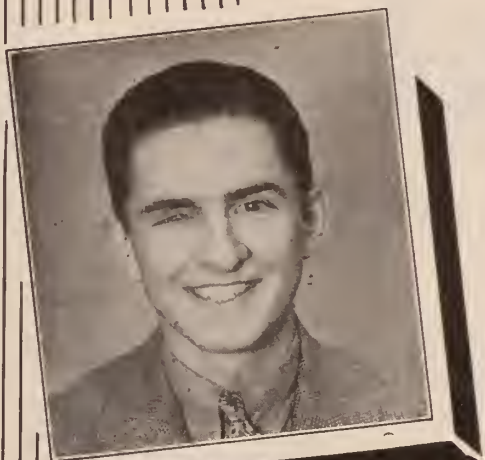
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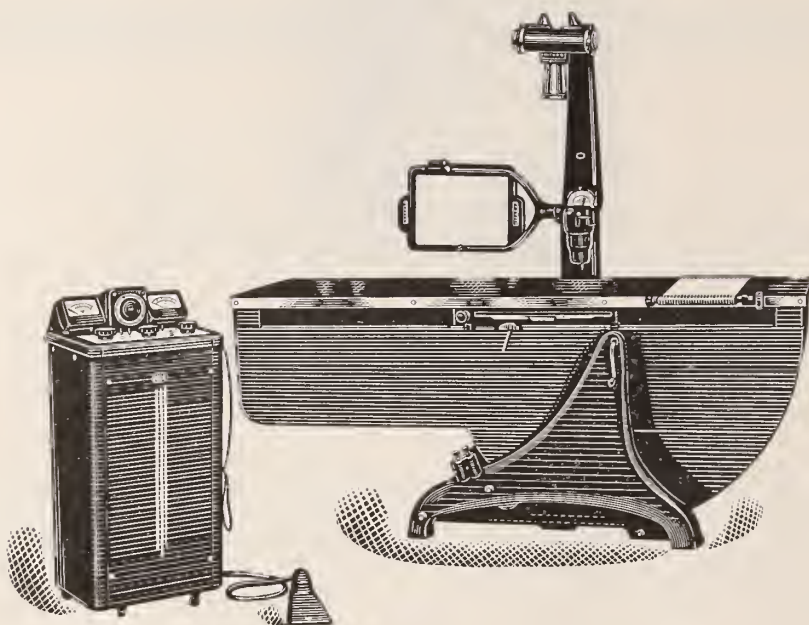
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# Timely Hints on Immunization . . .

*Diphtheria Toxoids Lederle*

*Smallpox Vaccine Lederle*

COOPERATING WITH THE NATIONAL PLAN of having all children over six months of age immunized against diphtheria and smallpox, public health authorities of several states are undertaking intensive drives of their own to secure the protection of a maximum number of children from these infectious scourges of childhood.

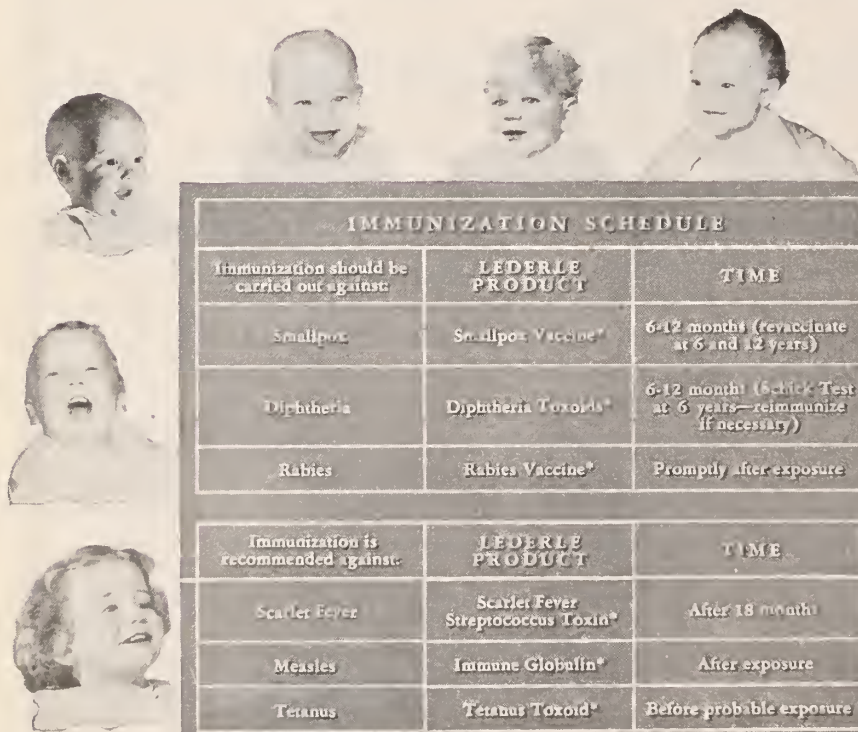
Statistics† show that there was an increase of over 1,200 cases of diphtheria in the country in 1941 over the number reported for 1940. The median for the five preceding years was almost twice the number for 1940. Let us not lose valuable ground gained—the upward trend in the incidence of diphtheria must not continue in 1942!

The method of diphtheria immunization most generally favored at present is 2 doses of alum precipitated toxoid or 3 doses of plain toxoid. In addition, the Department of Health of New York City has adopted the plan of urging that a single supplemental dose of 1 cc. of plain toxoid be given shortly before entering school to all children who have previously been immunized during infancy.

Smallpox incidence in 1941 reached a new low,† and public health authorities and practitioners should be proud of this attainment! However, 1,368

cases of smallpox were reported in 1941. Since this is a preventable disease, it is obvious that the goal has not yet been reached.

†Pub. Health Rep. 57:23,24 (Jan. 2) 1942.



IMMUNIZATION SCHEDULE		
Immunization should be carried out against:	LEDERLE PRODUCT	TIME
Smallpox	Smallpox Vaccine*	6-12 months (revaccinate at 6 and 12 years)
Diphtheria	Diphtheria Toxoids*	6-12 months (Schick Test at 6 years—reimmunize if necessary)
Rabies	Rabies Vaccine*	Promptly after exposure
Immunization is recommended against:	LEDERLE PRODUCT	TIME
Scarlet Fever	Scarlet Fever Streptococcus Toxin*	After 18 months
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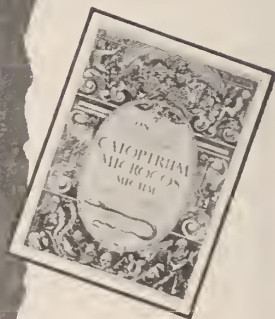
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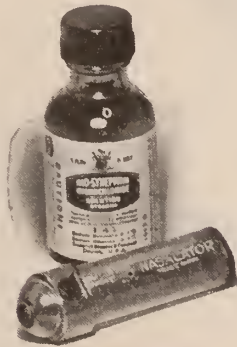


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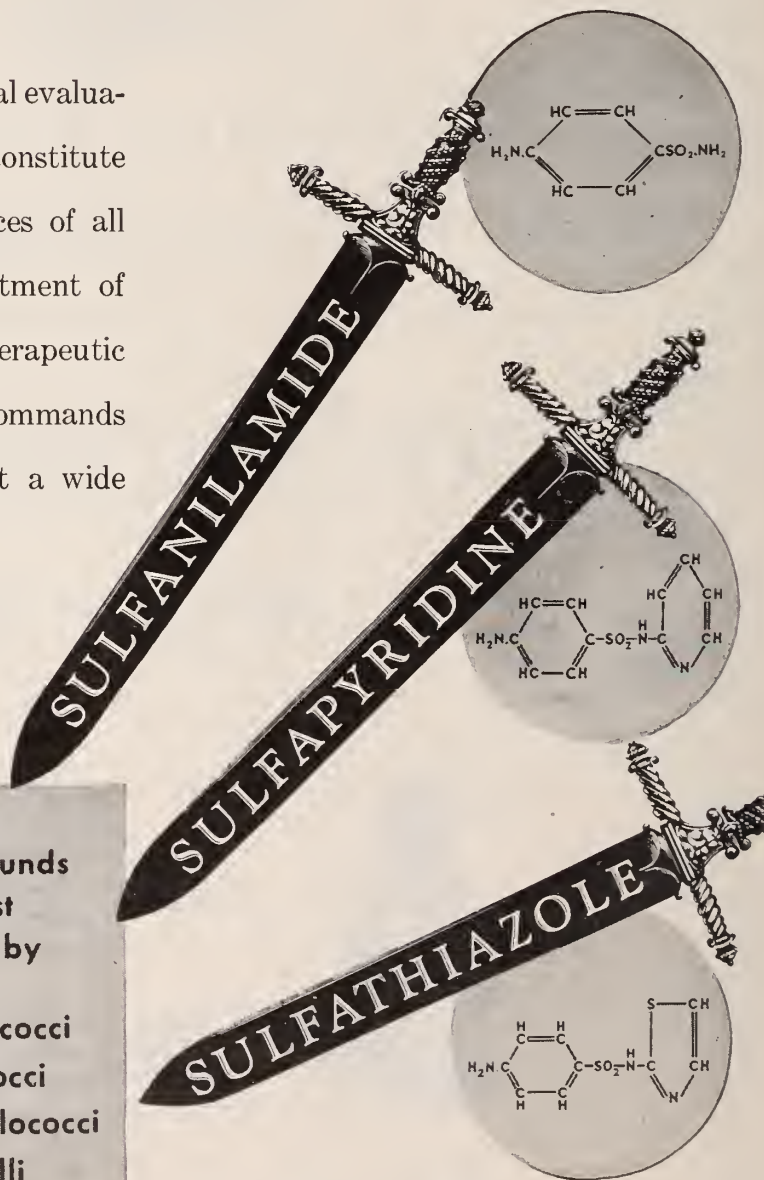
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IN ACTIVE SERVICE A. U. S.

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## THE ANNUAL MEETING TRANSACTIONS

The content of the *published* Transactions should be the *essential information* needed by the members to properly inform themselves upon the aims and activities of The Medical Society, the ways and means employed, and the amount and distribution of the cost involved in the conduct of the program and the plans adopted by the Society for the administrative year. The stenotypist's records contain practically all of the words spoken at the Annual Meeting Sessions for which she is engaged, but it would be costly, of limited interest and value, and at times undiplomatic for all of this permanent record to be supplied to each member. For the current use of officers and executives, the *original record* of the transcribed notes of the stenotypist is always available, as it is to any interested member, but this record is and should be used chiefly as a *reference*.

In recent years the Publication Committee has approved the printing of an *abstracted*, easily read and understood version for the use of members, issued as a supplement to *The Journal*. The Executive Officer uses an even more concise and clear summary of the *essential proposals* made at the Annual Meeting, and of the *actions taken* by the House of Delegates at their meetings. On pages 451-452 is shown such an abstract of essential information which the Executive Officer keeps at his side to assist in follow-up on the recommendations made at the Annual Meeting.

Our individual members are busy men. The more condensed and essential the material which is called to their attention, *the more members will read and understand it*, and the better the teamwork which results. Words can clutter

up as well as clarify a statement. A clear, concise and pertinent written statement is a work of art—it is unfortunately a rare achievement for some of us. Many a spoken sentence which sounded brilliant was made so only by the personality of the speaker. When reduced to cold print the statement seems commonplace or confused. Another important consideration is the expense involved when unnecessary words are printed (at fifteen to twenty dollars a page). The stenotypist must also be paid by the folio (250 words) for taking down these words. Then there is the editing cost of eliminating them. In addition are the costs

represented by the time necessary for the member to seek out information buried in words. Printing of the Transactions has cost us on an average \$800 a year. This cost can be cut down by further condensation without loss to the Society. Last year a much condensed version was published without comment, pro or con, from the membership.

The Editor would like to hear your comments as to how much nonessential detail you want. Strict economy is now essential, but it must be *real* economy (in terms of value received). Your Publication Committee is also interested in such economies.

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### THE PEST

The telephone in the Executive Offices rang and an excited voice asked, "Can a doctor refuse to see a patient?" The answer was given that a doctor has the same privilege as a patient in the matter of "free choice", but that a doctor would not be expected to refuse aid in an *emergency*. The follow-up on this case revealed some interesting facts of which the public is too often not informed. It seems that the patient in this case had consulted doctors so extensively and in so many places that no one doctor ever had an opportunity to adequately study the case and treat the patient. Incidentally the patient showed no interest in the doctor's bill when presented—none had ever been paid. The patient's demands were always unreasonable and he spent most of his time advising the doctor. His own condition and needs he recited on each visit, instead of listening to the advice given. This patient ignored the advice given and blamed the doctor for the real or imaginary ills at every opportunity, while at the same time he endeavored to further impose upon the doctor's time and service

without thought of compensation or the rights of the doctor to a consideration of his other obligations, responsibilities and desires. This patient wanted the Medical Profession as a whole to endorse *his* procedure and proposals, and to wreak vengeance upon members of the profession in good standing who differed with him. He was well known to many doctors in the state for he had at one time or another imposed upon each of them and they remembered him only too well. He wrote letters most uncomplimentary (and unwise). He is the kind who often drags in an innocent champion who later learns that the facts are not always as represented by his kind, and that one may even with good intentions invade a hornet's nest to his sorrow and embarrassment. But we must remember that the Lord himself got one bad one in twelve—*purposefully*—to show us that our lot is not wholly without precedent, and that even we may discover a renegade within our own ranks, though the profession will no doubt stand up well in any general comparison.

## SKELETONS

It should not be difficult to convince M.D.'s that a skeleton is a good basis on which to base our growth and development. All skeletons are not necessarily composed of bone, and ideas can be grown and developed on a skeleton of a few essential words or sentences. Students use "skeletons" to help study the subjects assigned. Pellagra, for example, has four Ds—dermatitis, diarrhea, dehydration and dementia.

The newspaper reporter bases his story on the five essential Ws—who, where, when, what and why.

The executive bases his procedure on objectives, programs, plans, schedules, costs and criteria of accomplishment.

The physician thinks in terms of history and examination of patient, cause, prevention, control (treatment), and prognosis of disease.

The medical profession is now faced with the problem *group* service. A new development has come along in distribution and cost of medical service to individual members of a group. Costs are shared through regular payments into a fund and are discussed in terms new to the private practitioner, viz., eligibility, scope of service offered, statistical pro-

cedure to be followed in records and reports. A third party brings patient and physician into contact, arranges contracts and periodically collects money from all subscribers to form the pool from which the service charges of the physician are paid. This *skeleton* of essentials will help private practitioners to better understand and coöperate in the developments resulting from trends determined by the *public*.

We must face the fact that these trends are influenced by many factors beyond our control.

Experience gained by our members in service with the Medical Corps of the Armed Forces will do much to show our members the advantages and disadvantages of organized effort and of group service, if they will observe without prejudice the operation and benefits of medical organizations. The dollar of the post-war future must purchase more than it ever did before, both in quality and quantity. Teamwork alone can bring such results. America is the crowning achievement of teamwork among people who came here primarily because they did not like their teammates at home, and wanted to conduct their lives on the skeleton of the "four freedoms".

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NEONATAL DEATHS IN NEW JERSEY IN 1940

In the July *Journal* we published an article by Dr. Julius Levy titled "Neonatal Deaths in New Jersey in 1940". We apologize to Dr. Levy for omitting to credit this article to him as was our intention. We also wish to urge all mem-

bers to carefully read and study this significant contribution which is of practical value indicating where to concentrate our efforts with greatest expectation of lowering mortality in this age group.



# THE WAR

## LESS NEUROSES IN WARTIME

An article in the July issue of *Hygeia* by Dr. Walter Freeman of Washington, D. C., points out that many neurotic patients in England are now enjoying better health than ever before. Data on the neuroses in other countries are not yet available and national temperament may be a factor which varies greatly among nations.

To explain the paradox that all the deleterious factors in connection with war, including fatigue, privation, malnourishment and disturbed rest, seem to result in improvement of mental health, Dr. Freeman cites six factors.

"First and foremost," he says, "comes the difference between big things and little things. It is the little things of life with their constant provocations that bring us to distraction, whereas we can always find the requisite strength within ourselves for facing major cataclysms. \* \* \* When there is no choice, action is automatic.

"Second is the difference between anticipation and action. We are psychologically constituted so that the anticipation of the future is always more horrendous than any actuality. \* \* \* Catastrophe gives people a chance to do something, to pursue a policy of activity, even though the activity is useless. \* \* \*

A third factor important in keeping mental health in wartime is, Dr. Freeman says, hatred, which can be an energizing, purifying hate that burns away the mists of petty selfishness and causes the individual to band together with the stranger, or even with his erstwhile enemy, for the common good. Hate is the response of a person who has been startled from his complacency by some fearful experience.

"The fourth point concerns organization and discipline," he continues. "In normal times we jealously guard our freedom, even though this freedom includes freedom of choice, which is difficult and mentally fatiguing and therefore productive of neurosis. In emergencies people look to their leaders for leadership and organization. Their confidence rises when they find themselves members of a group. \* \* \*

Two other reasons which the physician suggests for emotional stability in wartime are spiritual organization, which gives one a sense that God is watching over him, and self-sacrifice, which leads one to enter into some useful work to assist the common cause.

"To sum up," Dr. Freeman observes, "in the present crisis we have little to fear from mass breakdowns. Neuroses will occur in the susceptible, but probably less frequently than in peacetime."

## FIRST AID DRESSING

### MILD TINCTURE OF IODINE, U. S. P.

Every pharmacist should be able to make this product. The formula is as follows:

	<i>Metric Formula</i>	<i>Alternative Formula</i>
Iodine . . . . .	20 Gm.	146 grains
Sodium Iodide . . . . .	24 Gm.	175 grains
Diluted alcohol to make . .	1000 c.c.	1 pint

Dissolve the iodine and the sodium iodide in sufficient diluted alcohol (equal parts of alcohol and water) to make 1000 c.c.

*The label.*—This tincture should be labeled somewhat as follows:

MILD TINCTURE OF IODINE  
Contains 46 per cent Alcohol

*Cautions.*—Note that the *Mild Tincture* contains sodium iodide as the preservative not potassium iodide. Potassium iodide is used in Lugol's Solution and also in the regular, strong

(7 per cent-iodine) tincture which druggists usually sell when "Tincture of Iodine" is called for. It has been demonstrated that sodium salts are much better suited for application to a wound than potassium salts. Sodium salts are normally present in tissues and serous fluids. The strong (7 per cent) Tincture of Iodine should never be applied to a wound. It evaporates quickly, due to its high alcohol content, leaving crystals of free iodine in the wound, injuring the tissues, and preventing healing.

For these reasons pharmacists should always sell the U.S.P. Mild Tincture of Iodine for First Aid, not the strong Tincture; neither should they prepare the Mild Tincture by diluting the strong Tincture for it will then contain potassium iodide, not sodium iodide, and the alcohol percentage will not be correct.

*Help promote the wide use of the U.S.P. Mild Tincture of Iodine for First Aid dressings.*

## ORIGINAL ARTICLES

### EPIDEMIOLOGY IN WAR TIME<sup>1</sup>

By JOSEPH A. BELL, Passed Assistant Surgeon, U. S. Public Health Service<sup>2</sup>  
Bethesda, Md.

Among the many liberties enjoyed in this great nation is the one which permits us to select a profession dedicated to the alleviation, cure, and prevention of human disease. Now we are engaged in a war to determine whether such liberties shall continue to exist on this earth. We physicians, with the protection and aid of free agencies permitted under our government, have had the privilege of a medical education gained in institutions of free thought. We, therefore, find ourselves specially fitted to play an important rôle in the protection and preservation of these liberties.

We have a real task at hand, one that requires every moment of our time and every ounce of our energy. There is no time to quibble over the common association of war, famine, pestilence and death. Time is now too precious to discuss at length the historical scourges of smallpox, plague, typhus and cholera which follow in the wake of war, decimating entire populations. During and after the World War, Eastern Europe, which was hardest hit by famine, suffered great epidemics of typhus fever, relapsing fever, cholera, dysentery, and typhoid. Malaria raged in and about endemic foci. Smallpox was more widespread, even in Germany where vaccination had been practiced for so long. Influenza became pandemic and is estimated to have claimed 22 million lives.

The disease death rate has always exceeded the battle death rate in United States troops. In the Mexican War (1846-48) the disease death rate was seven times the battle death rate; it was twice the battle death rate in the Northern Army in the Civil War; it was five times the battle death rate in the Spanish War (1898), and in the World War still remained higher than the battle death rate.

Let us examine the record of the United States Army from April, 1917, to December, 1919. The 19 top-ranking infectious diseases are reported to have caused nearly 36 million man-days lost from duty.

These men were not all ill at the same time, but days lost by them were numerically equivalent to the complete disabling of an army of 360,000 men for a period of more than three months. In addition, those men who were ill required the services of physicians, nurses, cooks, attendants, ambulance drivers, litter bearers and other personnel. A vast store of equipment and supplies was needed to maintain and transport them. Furthermore, men who died or were discharged from the Army as a result of infectious diseases were a total loss to the fighting forces. Thus, a large number of man-days not included in the above figures were lost.

As a group, influenza, bronchitis and pneumonia were the infectious diseases most important in reducing effective military strength. These respiratory infections accounted for nearly one-half of the 36,000,000 man-days lost because of infectious diseases. The venereal diseases accounted for nearly one-fifth of this time loss, and mumps and measles for one-sixth. Dysentery and tuberculosis together accounted for one-ninth of the man-days lost from infectious diseases. These figures show the relative importance of specific infections in the last war.

Whether our experience in the present war will be comparable or not, it is clear that advantages will accrue to that belligerent nation which best mobilizes and effectively applies medical knowledge to the control of infectious diseases.

In fact, a review of disease experience in past wars would undoubtedly demonstrate a close relationship between epidemics and the outcome of military action. The magnitude and

1. Read at General Medical Session, The Medical Society of New Jersey, Atlantic City, April 21, 1942.

2. Division of Infectious Diseases, National Institute of Health. U. S. Public Health Service.

nature of such epidemics appear to depend upon the duration, size and theater of military activities and upon the application of control measures among both military and civilian populations.

It is not possible to predict the magnitude of future epidemics nor the specific diseases which will play the most important rôles. This war differs from all other wars. Military action dwarfs in size and scope that of any previous conflict. The theaters of war already encircle the globe. Civilian populations are involved to the same extent as the military forces. Industrial production in civilian areas is hardly second in importance to the fighting strength. The enemy strives to cripple industry, to starve, demoralize and disorganize populations and wreak havoc with their normal mode of life. Epidemics, under such conditions, are aid and comfort to the enemy.

Clearly, then, one of our most urgent and important duties is the control of communicable diseases. The job requires teamwork and full coöperation among civilian, military and public health physicians.

#### EPIDEMICS AND HOST-PARASITE RELATIONSHIPS

Certain fungi, viruses, rickettsia, bacteria and animal parasites may be considered as parasites of which man is a host. Parasites of man are—in the biologic sense—members of the plant or animal kingdom living in, on, or with man, at whose expense they are maintained. Parasites have been classified as facultative and obligative. Facultative parasites are capable of maintaining a life cycle independent of the host. Obligate parasites are wholly dependent upon their hosts.

It is not beyond reason to consider that parasites of man, like other forms of life, have instincts of propagation and race preservation. If this be true, it would not be to the best interest of parasites to kill all the hosts or suddenly to render a large proportion of them unsuitable for parasitic existence. This would be particularly true with respect to obligate parasites.

Thus the relation between human hosts and parasites may be one of adaptation. When adaptation is poor, invasion of the body by the

parasite causes an acute reaction wherein either the host or the parasite is promptly vanquished. The host-parasite relationships in smallpox and yellow fever are examples. On the other hand, when adaptation is very good, invasion of the body by the parasite causes no appreciable reaction and host and parasite may live together successfully for relatively long periods of time. The colon bacillus relationship is an example. An intermediate degree of host-parasite adaptation is exemplified by the meningococcus and the diphtheria bacillus.

Let us try to view the world through a wide-angle lens and observe the distribution of human hosts and parasites. We note comparatively large areas wherein man is settled with long distances separating families one from the other. Here and there small groups of families are concentrated in villages and towns, and at other places large groups of people are crowded together in cities.

In peacetime the situation is relatively stable. People living in one locality have comparatively close and frequent contact with each other. Their contact with people from other localities is remote and infrequent. The movement of people from one place to another involves a small proportion of the population and is limited by the economics of transportation. The population of each locality may become accustomed to certain strains of a parasite and a fair amount of adaptation may exist.

In wartime the situation is different. Great masses of individuals—military units, industrial and agricultural workers, refugees, and others are moved from one locality to another with unprecedented speed and without reference to peacetime economics of transportation. Thus the relative stability of host-parasite relations may be seriously upset.

The distribution of parasites of man through the world is not easy to visualize. Present knowledge is insufficient, but we do know that many parasites require certain environmental habitats for their presence to become apparent. The parasites causing such diseases as influenza, measles, chickenpox, whooping cough, diphtheria, syphilis, gonorrhea, and poliomyelitis are distributed throughout the world wherever man exists. These are obligate parasites



having, so far as we know, no other natural or intermediate host and depending for their existence upon successive passage from man to man. Thus their presence and spread depend, in the main, upon the intensity, frequency and number of human contacts. Of course the number and virulence of the parasites, the number and susceptibility of the hosts, period of infectivity, seasonal influences, and other considerations play important rôles in the occurrence and spread of these diseases.

The significance of human intercourse is well illustrated by Panum's experience in the Faroe Islands in 1846. The islands were relatively isolated from commerce and the small population was not large enough to maintain measles by consecutive passage of the parasite from one person to the other. Not enough babies were born to replenish continually the supply of new susceptibles in the population. Now what happened? After a period of 65 years during which no case of measles occurred, the disease was introduced to the islands by a case on an incoming ship. Of course, a tremendous epidemic occurred; islanders of practically all ages were stricken.

Parasites causing diseases such as malaria, yellow fever, plague, typhus, Rocky Mountain spotted fever, relapsing fever, and many others are not directly transmitted from man to man. Part of the life cycle of these parasites is spent in another host. Thus their distribution is limited to places inhabited both by man and the other hosts. To illustrate, we do not have malaria in the Hawaiian Islands because no anopheline mosquito vectors exist there. The islands, so far as we know, have a climate and terrain which is particularly suitable for these anophelines, but the distance and mode of communication between the islands and our West Coast, where anophelines are prevalent, has precluded the establishment of this species of mosquito in the islands. Because of the persistence of the infective plasmodium parasites in the blood of the human hosts for comparatively long periods of time, the parasite has been introduced to the islands on many occasions but cannot establish itself in the absence of an anopheline host. Since air transportation has decreased the time of travel from

the West Coast to the Islands from five days to 12 hours, the danger of establishing anopheline mosquitoes in Hawaii is increased. Control of the situation requires meticulous Federal quarantine procedures. Will the exigencies of war permit continued protection?

Let us consider yellow fever. The parasitic virus causing this disease is poorly adapted to man. Invasion of man causes an acute reaction wherein either the human host or the parasite is promptly vanquished. Today the yellow fever parasite has but limited distribution on the earth. It exists only in remote parts of Africa and South America. In the past when the parasite was spread over wider areas, it was an obligate parasite of two hosts, man and the *Aedes aegypti* mosquito. These two hosts still live in close association in many parts of the world. This is true in India, in the Philippines, and throughout our Southern States. The disease once existed in this country, but it has disappeared. Barriers have been established to prevent the passage of the parasite from the mosquito to the human host and quarantine vigilance has prevented its reintroduction. The disease has never occurred in India or the Philippines probably because the poor adaptation of the parasite did not permit it to survive the comparatively slow transportation from endemic areas to that part of the earth. Now the situation is different. Rapid air transport requires vigilant quarantine attention. The present war, with its unprecedented rapid movements of large groups of men to all sections of the globe, increases the potential danger of the disease.

In line with this concept of host-parasite relationship, the general procedures for communicable disease control may be outlined under three headings:

1. Measures to minimize spread of infections.
2. Measures to minimize the effects of infection.
3. Measures to minimize the effects of disease resulting from infection.

A distinction is made between infection and disease. Many parasites, such as those causing pneumonia, scarlet fever, dysentery, meningococcus meningitis, and diphtheria are fairly

well adapted to the human host and are frequently present in the host without producing acute disease. Diphtheria is a well-known example. Studies have shown that for every case of the disease (clinical diphtheria) there are many persons who are *carriers*, i.e., persons *infected* with virulent organisms but who never become recognizably ill. Carriers may disseminate the infection in the community perhaps more extensively than persons ill with the disease, because carriers are not recognizably sick, they are not bed-ridden and are not isolated.

This concept, however, does not nullify the public health practice of isolating patients ill with these diseases. The fact that it is not practical to isolate every carrier, i.e., every source of infection, does not justify permitting dissemination of infection from a patient suffering from the disease, particularly when the volume of obviously pathogenic parasites in the patient is greater than in the carrier. It has been shown that a child living in the household with a case of diphtheria is about twelve times more likely to develop a case of clinical disease than is a child of the same age exposed to a carrier in his school room. Furthermore, isolation and reasonable quarantine not only help protect others but are of definite benefit to the person who is ill. These practices permit better rest and minimize the possibility of infecting the patient with other pathogenic parasites.

Control measures other than quarantine and isolation, likewise designed to minimize spread of infection, involve: (1) Alteration of the environment to break chains of infection, and (2) rendering the infected non-infectious. Examples of the former include screening of patients infected with malaria, yellow fever, dengue, typhoid fever; mosquito control; pasteurization of milk; chlorination of water supplies; rat-proofing of buildings and many others. Perhaps the most notable examples of artificially rendering the infected non-infectious are: prompt arsenical treatment of early syphilis; sulfonamide treatment of gonorrhea; quinine and plasmochin treatment of malaria; anthelmintics for intestinal parasites; and delousing for ectoparasites.

The second objective in the control of com-

municable disease is to minimize the effects of infection. This involves increasing human resistance to diseases by specific and non-specific measures, and by delaying the occurrence of disease in infancy to a less hazardous period of life.

The value of specific active or passive immunization of persons against such diseases as smallpox, diphtheria, tetanus, pertussis, and measles is well known. Specific immunization, together with isolation, are recognized methods for the accomplishment of the objectives previously mentioned, minimizing the effects of infection. As for non-specific measures that increase resistance, it is generally felt that malnutrition, lack of essential vitamins, poor housing, extreme fatigue, unaccustomed activity, as well as other factors adversely affecting general physical well-being, lower resistance to infectious diseases and aggravate the seriousness of the attack. There is evidence supporting this view but little real proof. For example, before the last war, the tuberculosis mortality in Central Europe, as in other countries, was declining, but during the starvation years of the World War, the death rates from this disease increased in Central Europe by as much as 75 per cent, and continued inordinately high during the post-war period. There were many complicating factors to be considered, but there seems to be little doubt that malnutrition was in part responsible for this increase in tuberculosis in Central Europe.

The third group of general procedures for control of communicable disease includes measures to minimize the effects of disease resulting from infection. These measures comprise specific and non-specific treatment to prevent disability and death—specific serums, globulins, chemotherapeutic agents, oxygen tents, respirators, and the entire array of materia medica.

Physicians can cooperate with local authorities to assure that water, milk, and food supplies and distribution systems are safe and sufficiently protected to function during emergencies. They can also do much toward the immunization of all children against diphtheria and smallpox.

The poor vaccination status of the general

population and the mild type of smallpox which prevails in this country are facts long recognized. In comparison, the State of New Jersey has done a good job of smallpox vaccination. It is also generally recognized that 50 per cent of persons successfully vaccinated against smallpox lose most of their immunity within 10 years and again become susceptible to virulent smallpox. Our military forces are completely revaccinated. It would be wise to revaccinate our industrial army as well. A word of warning is, however, in order. Vaccines which are not fully potent have at times been unwittingly used for primary vaccinations. For revaccinations such vaccines are not only useless but harmful in that they create a false sense of security.

In the last war venereal disease was second in importance of all disabling infectious diseases. Unified action on the part of the medical profession can do a great deal to control the spread and cure of syphilis and gonorrhea. In the present emergency such action is a moral obligation. Education of the public, early recognition of cases, isolation, prompt and adequate treatment, efficient reporting, tracing and properly treating sources of infection and contacts will do much to put venereal disease at the bottom of the list of diseases crippling our war effort.

Coördinated action by civilian, military and public health physicians can and will do much to speed this war to a victorious end.

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### JAPANESE HEALTH HAZARDS

The Japs have joined with the Nazis in unprovoked attacks upon peaceful and productive countries. They had accumulated materials in great quantities because they are *materialistic* rather than idealistic in their viewpoint. Their cry, like that of the Nazis, is for *Lebensraum*—but they have a population density of only 490 per square mile while England has 700 per square mile and Belgium has 706. All three of these countries are industrialized and must all import foodstuffs. There is, therefore, evident inconsistency between the Japs' plans for cannon-fodder population *increase* among their own people, while complaining at the same time of *congestion* of their population. Their birth-rate is almost *double* that of the United States, but their mortality rate is also higher—i. e., 17.4 per thousand against 10 or 11 per thousand in our own experience. The men 20-44 years of age in Japan number 11,000,000, while the men of this age-span in the United States total 25,000,000 in peacetime. Not only are all military losses increased in wartime, but the civilian losses may at times even exceed these because battle-areas are no longer clearly demarked and civil sani-

tation is seriously upset under war conditions and might cause widespread epidemics. This is especially true if Japanese cities and towns are bombed. Deficiency diseases become more prevalent in war times when food is limited in quantity and quality. Deaths in Japan from tuberculosis are already 204 per 100,000, against 45 per 100,000 in the United States. Japanese deaths from diarrhea and enteritis are still 169, against 10 per 100,000 in the United States. While the United States has had a steady decline in the trend of birth-rates for some years, the sudden change in *trend* in Japan from an *increase* trend to one of *decrease*, has become a matter of great concern to the government. A new plan containing provisions for government bonus and other special favors to expectant mothers given to increase the birth rate in Japan to a point excelling all nations, has been modeled after the plan of Germany and Italy and is now being offered. Children so begot can hardly be envied by those born in this country and reared in The American Way.—Data from Statistical Bulletin, Metropolitan Life Insurance Co., of Dec., 1941.

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### LIFE EXPECTANCY

"At the age 35 the expectation of life is itself 35 years, so that a white person at age 35 may expect, according to averages, to live to age 70, which happens to be the oft-quoted biblical "three score years and ten". \* \* \* According to mortality in the United States,

the former figure has varied only from about 33 to the present 35—that is, by two years—in the last four decades, during which the *average* length of life has increased by almost 15 years."—Statistical Bulletin of the Metropolitan Life Insurance Co.



## EARLY DIURESIS IN CONGESTIVE HEART FAILURE\*

By CLARENCE L. ANDREWS, M.D., F.A.C.P., Atlantic City, N. J.

Congestive heart failure tends to recur more than once, in the average case of chronic hypertensive heart disease, once circulatory difficulties begin to manifest themselves, and this very fact suggests that certain changes must have taken place which disturb the circulatory balance in some hidden manner and which, when not promptly recognized and controlled, gradually lead to subsequent attacks.

If one reviews the hospital records of any group of these cases, he will be quite impressed by the pertinence of these facts. Many of these cases return to the medical wards two or three times within a period of one or two years with the same complaints, and they finally end sooner than is necessary in death because the disease has been allowed to advance to such a degree that further relief is no longer possible.

Upon their first admission to the hospital the response to treatment is usually spectacular, their relief from discomfort is dramatic, and they often are able to depart for home with a sense of security and a feeling that they are well. Upon their second visit, they are more incapacitated; their response to treatment is less satisfactory, and they go away from the hospital this time with an expression of uncertainty and a fear that they may have to come back again.

Although they usually try to follow their instructions this time with greater care than following the first visit, the processes which water-log the tissues are too insidious for the average lay mind to interpret, and unless they are carefully followed by a check-up or by some type of definite medical control, they are soon compelled to return to the hospital again, for the third and usually the final admission. He or she can now be regarded as just another case of chronic congestive heart failure whose circulatory organs will no longer respond to the previously tried and proven remedies which earlier gave them such wonderful relief, and,

in spite of all one can do, they gradually decline and finally pass away.

Let us retrace the chief points of interest in this same group of patients from the beginning of their circulatory difficulties and try to see if one can reconstruct the picture of just what has taken place. A great deal has already been accomplished in the past. Life insurance companies, in order to try to improve their death rates, have been the pioneers in this particular field.

Insurance statistics show that more people die of heart disease than from any other single cause. Of those who die of heart disease, more of them succumb to chronic hypertension than from any other disturbance. Of these chronic hypertensives, barring those due to hereditary tendencies or those usually referred to as the essential hypertensives, the greatest single factor in the cause of premature cardiac deaths is overweight.

Most chronic congestive heart failure cases occur in persons beyond the age of 50, probably due to their becoming less and less physically active—and this additional fat gain is usually deposited in the wrong places. The lower limbs get smaller and smaller and the abdomen, the chest and the hips become larger and larger.

Many of these individuals are very proud of this rapid gain in weight and it is often this sense of false security of weight gain that has frequently misled both the doctor and the patient as to just what is taking place.

If one will follow the daily diet, the fluid intake and the urine output of these patients over a definite period of time, he will soon observe that there has not been any appreciable increase in the daily food intake and that the rapid gain in weight is merely a gradual *retention of fluid in the tissues*.

Unless one is familiar with what is most apt to occur in such heart cases, and is constantly on the lookout for increases in weight, without apparent cause, *or a decrease in the urine output* in spite of the same 24-hour fluid intake,

\* Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, N. J., on April 22, 1942.

he will not detect this gradual water logging of the tissues until the added circulatory strain begins to bring about a break in cardiac compensation. In other words, if one waits until one can detect râles at the lung bases, or until he notices a swelling of the ankles, he will never be able to offset the decrease in circulatory efficiency which is most certain to follow.

These cases, themselves, soon learn how to detect a return of the body edema and will often tell the doctor that they feel the beginning restraint which it usually imposes upon them long before the usual physical signs of its presence are manifest.

The great body comfort, and the relief from smothering and oppression which they experience after the tissue edema has subsided, makes them constantly watch for the first signs or symptoms of its return and these patients will invite its removal rather than try to postpone it.

The practice of removing excessive fluid from the tissues to relieve the additional strain upon the heart is not a new thought. Physicians have known about it for many years and have attempted to remove it by many therapeutic agents, but it has not been until rather recent times that a more rapid or dramatic method of removal has begun to be sufficiently appreciated.

Congestive heart failure is an emergency disease and must be dealt with accordingly.

In practically every cardiac patient of this type there is a tendency for fluid to accumulate in the tissues and in many instances without any evidences of it, if one relies entirely upon the usual signs of swollen ankles and lung râles as the criteria so many physicians today are doing.

There is much clinical evidence to suggest that the rapid accumulation of this hidden fluid in the body tissues is one of the principal causes of the ever-increasing peripheral resistance which results and is the indirect cause of the cardiac decompensation because of the added myocardial strain.

Rest in bed, limited fluids, cardiac diet and digitalis have been the routine procedure in congestive cardiac failure for many years, and this regime is today still widely used in many

good clinics. But there is now at our command another routine which will remove the fluid in a most satisfactory manner, help to bring about compensation more quickly and spare the myocardium.

Edema of whatever degree, if allowed to crowd the tissues and cause resistance to the circulation and heart action for a few additional weeks, will require a much longer time for the heart muscle to regain its tone, and make the final outcome just that much more uncertain.

I have now under my care a group of private patients who illustrate very clearly the foregoing facts. I have been able to keep them in a fair state of circulatory efficiency by carefully watching them. They have not been cured, but they remain in reasonable comfort and unless some acute infection comes along or some intercurrent disease overwhelms them, they should live for quite some time.

The importance of removing edema from the body tissues does not apply to congestive heart failure alone, but it applies to any type of heart disturbance in which the cardiovascular system is in difficulties. Decompensation means that the myocardium is *losing* the fight. Any procedure which will lessen the work which the heart has to do by removing peripheral resistance is most desirable.

The chief point to always keep in mind is, that early edema is not easily recognized and may be present without much evidence. One must look for it and use the most dependable methods at his command—a fluid chart to detect it. This is the incipient and important stage.

If this fluid is not detected soon, the more advanced signs of the second stage will appear and one can detect both râles at the lung bases and a pitting of the ankles. If the edema advances still further and the patient can no longer lie down with comfort, he is now in the third or the critical stage.

Anyone can now diagnose the trouble at a glance, but much valuable time has been lost. It will not only require a much longer time to rid the tissues of the fluid and establish compensation, but the heart muscle will have been subjected to much more wear and tear than is

necessary and all other vital organs will have suffered from the associated and prolonged congestion.

Just as it is wrong to allow the body tissues to reach such a degree of edema, so is it poor practice to use only the simple diuretics to free the tissues of the fluid. Remedies like potassium citrate, caffein and caffein sodium benzoate are too slow in their action and too uncertain in their absorption to be depended upon in this type of case.

In looking over histories at the Atlantic City hospital of patients treated prior to several years ago, I found that from three to six weeks were required to rid these patients of their edema, and they returned systematically in their prior condition. Today we can relieve them in about half of that time, and when they coöperate they remain free and are much better than formerly.

*Method of Procedure.*—It was only by carefully reviewing our former histories that the correct answer to the problem of repeated admission of these cases was discovered. We realized the advantage of taking these cases earlier, and of following them up afterward. As soon as a case comes into my wards today, a complete physical examination is made and blood studies are done.

If there is any evidence of a fluid deficit and the edema is not due to a frank nephritis, and also the specific gravity of the urine is at least 1.015, 5 c.c. of decholin sodium and 1 c.c. of mercupurin or salyrgan are given intravenously at once. The advantage of giving decholin sodium with the mercurial is that it immediately changes the blood ph to the acid side, has a definite stimulating effect upon the congested liver which is usually associated with

cardiac decompensation, and it actually enhances the diuretic effect of the mercurial.

If there are no untoward effects from this dose, 10 c.c. of decholin sodium and 2 c.c. of the mercurial are given on the second day and this procedure is repeated every fourth day as long as is necessary.

After the edema is entirely removed, the same dose is repeated at weekly intervals or as often as the condition warrants to keep the patient in circulatory balance. Digitalis in suitable doses is also given to tone up and support the heart muscle.

Albumin and casts in the urine are not contraindications, if the specific gravity remains above 1.015. Usually the removal of the renal congestion will clear up the albumin and casts.

Before the patient is discharged, he is told of the importance of keeping up the digitalis as directed, and urged to report back to the clinic as soon as any of his former symptoms begins to appear.

#### SUMMARY AND CONCLUSIONS

1. Congestive heart failure is an emergency disease and must be dealt with accordingly.
2. The most important initial step is to get rid of the excessive tissue fluid as quickly as possible.
3. Decholin sodium combined with a mercurial prevents unnecessary delay and gives better and more lasting results than any other diuretic.
4. If congestive heart failure cases are followed up they can be controlled and helped to live a long time.
5. If one waits until pitting of the ankles and râles at the lung bases are apparent, much valuable time has already been lost.

1616 Pacific Avenue

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#### TREATMENT OF GINGIVITIS

Fourteen cases of gingivitis have been treated with massive doses of ascorbic acid without any other dental treatment such as scaling or mouth-washes. 300 mg. of ascorbic acid was given daily until a urine test showed that the patient was saturated with the vitamin. On an average a total of 2,000 mg. was

needed. The previously sore and inflamed gums became normal after approximately 4 days' treatment. The treatment should be followed by a maintenance dose.—H. G. Campbell and R. P. Cook. Brit. Med. Journ. (Clin. Abst., 1941.)



## ABDOMINAL PAIN OF UROLOGIC ORIGIN IN CHILDREN\*

By MEREDITH F. CAMPBELL, M.D., New York

Abdominal pain in children commonly demands surgical consideration and often presents a real problem in differential diagnosis. This communication directs your attention to the little recognized but relatively high incidence of urinary tract disease as the cause of abdominal pain in the young. We are here concerned predominantly with chronic pain in children whose condition does not demand emergency treatment, rather than with acute pain as observed in acute appendicitis, intestinal obstruction and the like, in which cases surgical exploration is urgently indicated even though the preoperative differential diagnosis may not be clear cut. Far better that abdominal exploration be performed unnecessarily in many children presenting the picture of an acute surgical abdomen than that a fatality should result from failure to recognize the possible emergency.

The clinical background for our observations has been the personal complete urologic examination of 213 children in whom abdominal pain was the chief complaint or was an outstanding symptom on admission to the hospital. In more than half of these, acute or subacute urinary infection was suspected from the first or was discovered after an early examination of the child. Yet in fourteen the original diagnosis was appendicitis, nearly always "chronic", and in thirteen others appendectomy had previously been performed for the same pain which persisted and again brought the child to the hospital. In some children subjected to urologic, gastroenterologic, extensive laboratory examination, and in a few, laparotomy, the cause of the pain still remained uncertain.

The most frequently encountered causes of abdominal pain of urologic origin are hydronephrosis, ureteral stricture, ureteral obstruction by aberrant vessel compression, and obstruction at the bladder outlet or in the deep

urethra. These and additional causes are indicated in the following table:

KIDNEY	URETER
Abnormally mobile	Stricture
Ectopic	Stone
Horseshoe	Kink
Fused	Diverticulum
Hydronephrosis	Compression by
Calculus	a. Aberrant vessel
Tumor	b. Fibrous bands
Pyelonephritis	
Pyonephrosis	BLADDER
Solitary abscess	Stone
Perirenal	Retention
Tumor	a. Neuromuscular
Cyst	b. Contracted outlet
Abscess	c. Prostatic obstruction
URETHRA	
Stricture	ADRENAL
Meatus stenosis	Tumor
Stone	Abscess
Valves	
Hypertrophied verumontanum	

Abdominal pain may result from an inflammatory process which is local as in appendicitis or widespread as in generalized peritonitis. The abdominal projection of pain through the vagus from an acute upper respiratory tract infection is well recognized. The sudden distention of a hollow viscus is one of the most frequent causes of abdominal pain and may vary from the intestinal gas bubble which produces colic in the infant, to severe intestinal obstruction and distention by bands, angulation or intussusception. Constipation, on the other hand, rarely causes pain.

For the greater part, the pains with which we are here chiefly concerned result from gradual or rapid *distention* of the collecting part of the urinary tract above a point of obstruction. Pain also results from swelling of the kidney within its dense and relatively inelastic capsule; the renal swelling may be due to acute inflammation of infection or trauma (including stone), obstruction, tumor, and so forth, or may develop more slowly when mild ureteral obstruction exists. But I repeat for emphasis, the urologic lesions which cause abdominal

\* From the Department of Urology, New York University College of Medicine. Presented by invitation before the Surgical Section of The Medical Society of New Jersey, Atlantic City, April 22, 1942.

pain are predominantly obstructive and may be situated anywhere between the renal calyx and the urethral meatus. Complicating infection materially adds to the gravity of the situation as well as to the difficulties in differential diagnosis. On the other hand, it cannot be too strongly emphasized that grave urologic lesions may exist despite the presence of normal urine.

Persistent pain or swelling along the course of the urinary tract urgently demands a thorough urologic investigation. Prompt urinalysis of a properly collected specimen is assumed and in the female should always be collected by catheterization. In addition to urinalysis, physical examination and an excretory urographic study certainly represent the minimum investigation, yet these are frequently confusing or inconclusive. When the excretory urograms are not clear-cut and readily interpreted, employ the ureter catheter and retrograde pyelography promptly; experience with only a few cases of this type will demonstrate the wisdom of this recommendation. In lower abdominal pain the presence of vesical residual urine should be determined.

An anomalous organ is more prone to disease than the normal one. About 10 per cent of all children are born with urogenital tract abnormality and in about a third of these cases there is urinary obstruction; congenital ureteral stricture is the commonest single lesion. Urinary stasis is the usual prime result of upper urinary tract malformation; the calibre of the obstruction may be broad or narrow. The obstruction may result from changes in the wall of the ureter as in stricture, from extraneous compression as by aberrant vessels, or from an abnormality in the course of the ureter as, for example, in renal ectopy or horseshoe kidney disease.

Rarely in children does abnormal renal mobility cause acute ureteral obstruction by sharp angulation at the ureteropelvic junction or in the upper ureter; hence Dietl's crises are seldom observed in early life. Yet the condition may cause sharp pain in the loin or in the abdomen and simulate the colic of ureteral stone or intraabdominal disease. Ureterographic studies made with the patient in the flat, upright and Trendelenburg positions will

demonstrate the mechanism of the pain production. If a belt will not adequately support the kidney and there is constant pelvic urinary over-distention, nephropexy should be employed together with the eradication of peripheral obstruction.

Occasionally the freely movable kidney will wander about the abdomen as it did in a six-year-old girl admitted to the hospital with a diagnosis of abdominal tumor. This mass, which could be pushed into all quadrants except the left upper, was slightly tender and had been thought most likely to be a mesenteric cyst. Yet urologic investigation showed it to be a congenital solitary right kidney on a long pedicle. A mild congenital ureterovesical junction stricture caused some ureteral dilatation. The condition was treated only by a renal suspension belt. A twelve-year-old girl was admitted to the hospital because of lower abdominal pain and tumor. At first it was thought she had a new growth; a suprapubic protuberance was readily seen as she lay flat on her back. Urologic investigation proved the lesion to be one of renal fusion; both kidneys were joined in one knarled mass overlying the sacrum and caused considerable pressure on the bladder dome. The pain resulted from traction on the renal vascular supply which came from the iliac vessels. Here only abdominal (renal) support with a suprapubic belt was required.

In an eight-year-old girl with crossed fusion of the kidney (her left kidney lay in the right lumbar gutter and was fused with the right), appendectomy had been performed one month previously because of sharp pain in the right side. The appendix was normal but the subsequent urologic examination disclosed a ureterovesical junction stricture of the duct leading to the right upper renal pelvis, and dilatation of this stricture cured the pains which had simulated those of appendicitis.

#### HORSESHOE KIDNEY

The horseshoe kidney notoriously causes abdominal pains which are often referred to the umbilical region. An eight-year-old girl had suffered sharp pain in the right upper quadrant for several months; her pediatrician was cer-

tain that gall-bladder disease caused the pain. He was so convinced of this that eight complete cholecystographic studies had been made as well as three complete gastrointestinal roentgenographic investigations. All were negative. Excretory urographic study was suggested and indicated a mild right hydronephrosis. The examination was completed with ureteral catheterization and retrograde pyelography; the final diagnosis was horseshoe kidney with congenital ureteropelvic junction stricture on the right side with massive infected hydronephrosis. There was mild dilatation of the left kidney pelvis with a congenital stricture at the level of the fifth lumbar vertebra. The child was cured by resection of the horseshoe kidney; the right half of the organ was removed. Subsequent periodic dilatations of the congenital stricture in the left ureter were carried out. The child was promptly relieved of all symptoms, her digestion improved and she gained rapidly. A nine-year-old boy with a horseshoe kidney was admitted to the hospital with acute pain in the right loin and a temperature of 104° F. The diagnosis of acute appendicitis was made and operation was performed at once. Upon opening the right anterior abdominal wall, the operating surgeon entered a large cavity filled with purulent urine; drains were inserted. The boy's temperature rapidly returned to normal but urine continued to drain from the wound for several weeks, after which the boy came into my hands. Urologic examination showed that he had a pelvic horseshoe kidney, the left half of the organ was located over the sacrum while the other half extended up into the right lower abdominal quadrant, and there was a stricture at the right ureteropelvic junction. The pathologic mechanism was acute ureteral obstruction and acute massive hydronephrosis; exacerbation of smoldering infection of the hydronephrotic kidney explained the temperature and much of the pain. Since resection of the horseshoe kidney with the removal of the diseased right half, the boy's condition has been most satisfactory; the remaining left half of the horseshoe kidney excretes 70 per cent phenolsulphonphthalein in two hours and the urine is now sterile.

#### STRICTURE

In patients with stricture of the body of the right ureter, the diagnosis of chronic appendicitis is usually made and we now have seventeen cases illustrating this in children. In eight the appendix had previously been removed and in some instances was frankly reported as normal. In the others it was said to be "chronic"; one may suspect a pathologist's concession. Yet in all cases the original pain persisted and again brought the child to the hospital. It is appreciated that the acutely inflamed appendix overlying the ureter may cause the appearance of red blood cells and some leucocytes in the urine, and such findings must not misguide us. In the majority of patients in whom the erroneous diagnosis of appendicitis is made, the disease is said to be chronic. In such cases and when there is any question as to the accuracy of the diagnosis, 20 to 25 minutes can be spared for an excretory urographic study which in most instances will indicate any serious ureteral obstruction. It is this group with which the present discussion is most seriously concerned, and particularly to emphasize the importance of performing an adequate urologic investigation in all patients before subjecting them to an operation for so-called chronic appendicitis or "abdominal adhesions". In several of our country's larger hospitals and especially in the teaching institutions, this is now the accepted practice.

Aberrant renal vessels passing from the lower pole of the kidney mesially to the aorta or vena cava or to the renal pedicle, by compression are likely to produce a persistent ureteral obstruction and hydronephrosis which upon occasion may become acute. In rare instances aberrant uterine vessels block the lower end of the ureter. In our present study there were sixteen children admitted to the hospital because of persistent or intermittent abdominal pain, proved to result from upper ureteral obstruction by anomalous aberrant renal vessels. In five of these appendectomy had previously but fruitlessly been performed to relieve this pain. In eight cases the obstruction was eradicated by dividing the obstructing vessels; in the other eight children advanced renal destruction demanded nephrectomy.



Ureteral kinks and angulations of clinical importance are rare in children. In a five-year-old girl admitted to the hospital because of persistent left loin pain and who was thought to have surgical disease of the descending colon, urologic examination revealed a fixed kink in the upper third of the ureter. This kink persisted in urograms taken in the flat, upright and Trendelenburg positions. Treatment was surgical mobilization of the kink with nephropexy, and subsequent periodic progressive dilatation of the ureteral stricture located at the site of kinking. This stricture was either congenital and initiated the kink formation, or resulted from the long-standing angulation. At any rate, the therapy employed was thoroughly successful.

Diverticulum of the ureter is usually an appendix-like outbranching which, distended with urine, may produce obstruction by pressure on the ureter. In a five-year-old girl admitted to the Surgical Service because of persistent left abdominal pain, urologic investigation disclosed a ureteral diverticulum five centimeters long, and excision of the sac relieved her symptoms.

#### URETERAL CALCULUS

Ureteral calculus is unusual in the young and is less frequently seen in children today than formerly; doubtless improved dietetics with an increased vitamin A intake largely explains the decreased incidence. Nevertheless we have seen a few children admitted to the hospital and thought to have appendicitis and other serious intraabdominal disease, in whom urologic investigation has revealed ureteral stone. A four-year-old boy was admitted to the hospital with left loin pain radiating toward the testicle and increased frequency of urination. Members of the Surgical Staff stated they would think the boy had a ureteral calculus except that "it does not occur in children this young". Yet by urologic examination a triangular stone seven mm. in diameter was disclosed in the upper third of the ureter. Following cystoscopic ureteral dilatation, the stone progressed to the juxtavesical segment where it was held up by the crossing of the vas deferens. It moved no further during three

weeks of watchful waiting and was therefore removed by ureterotomy. At operation the stone was found so firmly ennested at the point of obstruction as to prevent further progress.

In 1937 the late Dr. Arthur Stein of Elizabeth called me in consultation concerning a twelve-year-old boy from whom he had recently removed a gangrenous appendix. Convalescence was uneventful until the tenth day, at which time the boy developed excruciating left abdominal pain with nausea and vomiting, shock, and marked intestinal distention. Dr. Stein strongly suspected acute intestinal obstruction; yet on one occasion during this episode, the pain had been referred to the testicle and there had been some urinary frequency. We performed an excretory urographic study at once; this suggested the presence of a stone about the size of a grain of rice in the mid-portion of the left ureter. Two hours later the stone was spontaneously passed and all symptoms were relieved. This case is cited as one in which a wholly unsuspected urologic condition may simulate an even more serious one (intestinal obstruction) yet relatively simple urologic survey spared the child an abdominal exploration at a critical time.

Lower abdominal pain frequently results from an over-distended bladder. Acute vesical over-distention is unusual in children except following operation. On the other hand, chronic vesical over-distention is not uncommon and is most often due to (1) neuromuscular disease (cord or atonic bladder), as we observed in seven children in the present study; (2) congenital contracture of the vesical outlet (one case); (3) congenital hypertrophy of the verumontanum (three cases); (4) congenital valvular obstruction of the prostatic urethra (five cases); (5) congenital stricture of the urethra and particularly (6) congenital stricture of the external urethral meatus (three cases). In two instances there was combined obstruction by hypertrophied verumontanum and congenital valves. In all of these conditions, dysuria or difficulty in urination is likely to exist. A correct diagnosis can be readily made by cystourethroscopy, and removal of the obstruction, usually by transurethral electro-resection employing miniature instruments, is readily ac-

complished. In the treatment of cord bladder disease of the retention type, modified resection of the vesical outlet together with the administration of acetylcholine derivatives, will generally enable the patient to empty his bladder completely.

Most urethral strictures in children are congenital; post-gonorrheal or traumatic strictures are indeed rare. Urethrotomy is seldom required; periodic progressive dilatation with steel sounds readily accomplishes the desired result. Stricture at the external meatus is easily recognized by the pinhole size opening. Sometimes secondary ulceration complicates the lesion, the child voids with a thread-like stream, accompanied by great straining and variable vesical retention is not infrequent. Liberal meatotomy and the maintenance of a normal urethral calibre by sounds constitute the treatment.

Occasionally torsion of an undescended testicle may simulate acute intraabdominal disease as we have observed in three young boys. In two the gland was at the external inguinal ring and in one it was intraabdominal. Moreover, untwisted improperly descended testes in

these locations and even in the inguinal canal may also be a cause of low abdominal pain. Surgical correction of the anomaly is the treatment. As a clinical corollary, palpation of the testicles is an important part of the abdominal examination.

#### SUMMARY

Attention has been directed to the relatively high incidence of urologic conditions which may produce abdominal pain in children. Varieties of ureteral obstruction are the most frequent, particularly congenital strictures and compression caused by aberrant vessels. No patient should be operated on for "chronic appendicitis" until adequate study has ruled out urinary tract disease as a possible cause of the symptoms. Although the urinalysis is usually abnormal in serious urinary tract disease, it must be recognized that even in the presence of advanced obstructive uropathy, the urine may be normal. Except in emergency cases, correction of the urologic disease may advisedly precede exploratory laparotomy as the first consideration will often render the second unnecessary.

140 East 54th Street

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### HICCUPS IN THE NEW-BORN

The commonest cause of hiccups in a newborn infant probably is aerophagia, *The Journal of the American Medical Association* says in answer to an inquiry.

In a two-week-old infant who hiccups after each meal the afferent stimuli probably arise in the stomach and are transmitted to the diaphragm through the phrenic nerve. In addition

to aerophagia this reflex may be initiated by too rapid nursing, the ingestion of unduly hot or cold milk or dilatation of the stomach.

If the nursing is interrupted and the baby held on the shoulder and patted on the back, the belching of air ingested with the milk will probably empty the stomach of a considerable air bubble and will prevent the hiccup.

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### HEMORRHAGE IN INFANTS

As a means of preventing hemorrhage, a hazard confronting practically all infants during the first few days of life, George P. Bohlander, M.D., William M. Rosenbaum, M.D., and Earl C. Sage, M.D., advise in *The Journal of the American Medical Association* that a

vitamin K preparation be given by vein to all mothers before delivery. The time of administration makes no difference in the results obtained. After about the sixth day of life the clotting factor of an infant's blood becomes normal.

## SYPHILIS OF THE NOSE AND MOUTH\*

ORAM R. KLINE, M.D., Camden, N. J.

Otolaryngologists are prone to regard pathology of the nose and mouth as a local condition, but very frequently it is merely the local manifestation of a systemic disease. If general conditions such as syphilis, tuberculosis, the anemias, endocrine imbalance, nutritional deficiency and the psychoses are constantly kept in mind, we may contribute valuable aid to the family physician in arriving at a correct diagnosis, and many unnecessary local treatments will be avoided.

The manifestations of syphilis in the nose and mouth are of particular importance. Acute luetic lesions in this area are a menace to society, since at this time the disease is readily transmitted by direct and indirect contact; furthermore if it is recognized in the early stages there is much more probability of effecting a complete cure by promptly instituting the indicated treatment. Chronic syphilitic lesions if not checked by early specific treatment will inevitably lead to destruction of tissue and permanent deformity which will be a life-long mental and physical handicap to the individual.

### PRIMARY SYPHILIS

Chancre of the nose is a rare condition and when it does occur the usual site is the skin lining the vestibule. Approximately only two per cent of the extra genital chancres are found in this location. The method of inoculation is generally indirect, that is, the *Spirachaeta pallida* is carried to this vascular area by unclean fingers, surgical instruments or some other object that has been in contact with a lesion of acute syphilis.

About the third or fourth week after inoculation the patient notices irritation and thickening at the end of the nose, usually accompanied by neuralgic pains in the head and eye on the same side. A hard indurated, irregular infiltration is noted with a rather deep, ragged ulcer coated with discharge. Probably more characteristic than the appearance of the sore

is the development of a hard, smooth and indolent gland in the submaxillary region of the affected side, the enlargement being out of proportion to the extent and duration of the ulcer. The homolateral post auricular gland also increases in size. The lesion tends to heal in six to ten weeks and usually there is no noticeable scar.

Since chancre of the nose occurs so infrequently, physicians are not alert to the lesion in this region and consequently may fail to make a correct diagnosis. The usual mistake is to regard it as some form of malignant growth; however it must also be differentiated from lupus, leprosy, glanders and furuncle.

Primary syphilis of the mouth occurs much more frequently. Although less than 10 per cent of all chancres are located upon portions of the body other than the genitalia, 70 per cent of these extra genital lesions are found in and around the mouth. The lip is the most common site, but they may also be found on the tongue, tonsil, posterior pharyngeal wall and occasionally on other areas of the oropharyngeal mucosa. Ordinarily there is but one lesion; however, multiple lesions may occur. Three clinical types are recognized: the erosive, the hypertrophic and the ulcerative.

The erosive chancre is the most common type; it may be very small and escape observation altogether or be lightly dismissed as a simple abrasion. The lesion presents a parchment-like induration, which is detected only by palpation, and is covered by a thin fibrinous-like membrane. If this membrane is removed there is a considerable oozing of serum, from which the *Spirochaete pallida* may be recovered and identified.

The hypertrophic chancre is larger and presents more marked induration.

The ulcerative type is generally the result of secondary infection of either of the other two types. The border of the ulcer is usually intensely indurated.

With the exception of an occasional ulcerative type, chancres are practically painless and

\* Read before Eye, Ear, Nose and Throat Section at the Annual Meeting of The Medical Society of New Jersey, April 22, 1942.



heal with barely a sign of scar tissue. The diagnostic points to be kept in mind are: induration, serous oozing, a freely movable and irregular enlargement of adjacent lymph nodes and the comparative lack of pain. The diagnosis is confirmed by the identification of the *Spirochaeta pallida* in the serum of the lesion. Serological examination of the blood may fail to give a positive reaction until several days or weeks following the appearance of the chancre.

#### SECONDARY SYPHILIS

Nasal manifestations of this stage of the disease are negligible; however mucous patches have occasionally been identified. The symptoms are comparable to those of a subacute coryza.

The mucosa of the mouth is affected to a varying degree during this acute generalized stage of the disease. Acute oral syphilis may develop at an early period of the acute Spirochetemia or after the cutaneous eruption has disappeared. The lesions may be macular, erosive, papular and ulcerative.

The macular syphilides are well defined, bright red, erythematous spots of varying size. As a rule they are not associated with subjective symptoms and may be easily overlooked.

The erosive syphide or mucous patch is most frequently observed as it is more characteristic in appearance. It may develop anywhere within the oral cavity but is more frequently seen on the labial mucosa and on the dorsum of the tongue. It begins as a small grayish spot, and when fully developed is round or oval and of varying size, but rarely over one-half inch in diameter. It is sharply defined and may or may not be surrounded by an inflammatory areola. If the gray covering is removed a readily bleeding, oozing surface is exposed from which the *Spirochaeta pallida* may be recovered and identified.

The papular syphide is rare and almost entirely confined to the dorsum of the tongue and the buccal commissura. The "split papule" type is usually seen at the commissura, that is, one-half of the papule on one lip and one-half on the other. This is rather characteristic and is sufficient to justify a serological examination.

The ulcerative syphide of the secondary stage is rare and is usually the result of irritation and secondary infection.

The diagnosis of acute oral syphilides cannot be made on clinical grounds alone. Many acute and chronic diseases cause or complicate lesions in the mouth, making the differential diagnosis very difficult. It often requires a thorough physical examination, a careful history, microscopic and serological studies, as well as therapeutic tests to confirm the diagnosis.

#### TERTIARY SYPHILIS

This is the most important form of syphilitic infection involving the nasal cavities. An early diagnosis is very important since there is often rapid and extensive destruction of soft tissues, bone and cartilage which causes irreparable impairment of nasal function and unsightly disfigurement.

Tertiary lesions rarely occur in less than two years following the initial infection and it is not uncommon for twenty or more years to elapse before the onset of nasal obstruction, the first symptom of gummosis infiltration.

The gumma is the foundation of the tertiary manifestations which include ulceration, perichondritis, necrosis and cicatrization. If a correct diagnosis is made before ulceration occurs and treatment is instituted, the subsequent destructive phase of the disease may be prevented. During this early stage the only symptoms are nasal obstruction and pain; the latter being referred to the nose, forehead or the head generally and is always worse at night.

Intranasal examination reveals an ill-defined tumor of diffuse infiltration, usually of the septum. It is deep red in color, feels firm when touched with a probe and does not shrink when cocaine or adrenalin is applied. There may be some edema, and tenderness on pressure over the bridge of the nose.

I recall two such cases, both of which responded promptly to specific treatment, although the blood Wassermann of one was negative.

The local obstruction and discomfort are relieved to a great extent when the necrotic

bone is exposed by ulceration. Fetid discharge and crusting is now the rule and the fetor is most objectionable. The putrifactive odor practically banishes the patient from society. The extent of the necrotic process depends upon the severity of the infection and the resistance of the patient. Usually it may be arrested at any point by adequate specific treatment. The destruction of tissue may be limited to a small perforation of the nasal septum or it may involve the whole septum and surrounding structures. Necrosis may affect the nasal bones, hard palate, and lateral walls of the nose leading to exfoliation of large pieces of the superior maxillae, ethmoids and sphenoids. The cranial cavity may be exposed and the patient succumb to fatal meningeal complications.

Chronic oral syphilis primarily involves the soft tissues but the bony structures may also be affected. Destruction of tissue occurs, which is followed by the formation of characteristic scars. This tissue destruction and cicatrization is often responsible for marked impairment of function, particularly when the palate and posterior pharyngeal wall are involved. The end result may be a complete partition between the nasopharynx and oropharynx. Another important consideration, often overlooked, is that a certain percentage of these late luetic lesions undergo cancerous changes either during or after the syphilitic activity.

Tertiary lesions occur on the lips, tongue, hard and soft palate, and pharyngeal wall. Since the tongue is most frequently involved, particularly in the male, the description of oral lesions will be limited to those occurring in this organ.

Three clinical types are observed, namely, the gumma, the gummatous infiltration and interstitial glossitis.

Gummas in the form of rounded nodules may be single or multiple, superficial or deep, and may vary in size. They usually originate in the lower muscle layers, later necrose and rupture, giving rise to deep ulcers and finally heal, leaving flat, smooth linear or stellate scars.

Gummous infiltrations may be so extensive as to more than double the size of the tongue.

Leukoplakia is often associated with this type.

Interstitial glossitis or lobulated syphilitic tongue may be superficial or deep. The mild superficial type is very difficult to recognize but careful palpation should demonstrate induration of varying degrees. The more typical deeper lesions are characterized by a lobulated appearance of the dorsum of the tongue, due to grooves and fissures varying in width and depth, while the mucous membrane between the grooves appears tense and comparatively smooth. In addition, there is an unmistakable sensation of induration when the relaxed tongue is palpated.

Since leukoplakia is so frequently seen in conjunction with tertiary lesions of the mouth a brief description of this condition is necessary. Leukoplakia may be defined as an intensely chronic inflammation of the mucous membrane which is characterized by a gradual development of irregular, circumscribed, hard, milk-white patches of keratinized epithelium with an ultimate tendency towards malignancy. The disease is brought about by local irritation in patients who have a tendency to hyperkeratosis. This tendency may be inherited or it may be acquired as the result of certain general somatic disturbances, such as: syphilis, endocrine dysfunction, avitaminoses, particularly a deficiency of vitamin A, hypercholesteremia and allergy. Serologic tests are indicated, as about 25 per cent have a positive Wassermann.

Tertiary lesions must always be differentiated from tuberculosis, malignancy and Vincent's angina. Chronic granulomata caused by trauma, pyogenic infections and foreign bodies may also simulate the appearance of a gumma.

#### CONGENITAL SYPHILIS

The early form of hereditary syphilis simulates the secondary stage of the acquired type. The symptoms usually appear at the age of two weeks to three months and are not unlike those of an obstinate coryza. The nasal mucosa is red and swollen, exuding a profuse discharge which is irritating to the skin, causing fissures and crusts around the anterior nares. The breathing is moist and noisy due to the nasal discharge and obstruction; "the snuffles", a descriptive term long identified with the

early stage of congenital lues. Painful fissures are frequently seen at the commissura of the mouth which give rise to white linear radiating scars when they heal.

The later form is analogous to the tertiary stage of acquired syphilis. It usually occurs between the third year and puberty, but may be seen at any age. Nasal obstruction first develops due to gummosus infiltration of the nasal mucosa followed by ulceration which is characterized by an extremely fetid discharge. As the disease progresses destruction of the cartilagenous and bony framework occurs, giving rise to the typical syphilitic stigma of "saddle nose" with turned-up tip.

In congenital syphilis the permanent teeth are usually altered in size, shape and texture. These changes may occur in the upper and lower incisors, the first molars and more rarely the canines. The following quotation from the writings of Sir Jonathan Hutchinson in 1857 clearly states the diagnostic significance of the permanent teeth. "The upper central incisors of the permanent dentition are the only ones which affords evidence beyond dispute. The chief peculiarity is a general dwarfing of the tooth, which is both too short and too narrow. Its sides slant, and it tends therefore to become pointed. The tendency to point is always defeated by the cutting off of the end of the

tooth by a line curved upwards so as to produce a single shallow notch."

It must be borne in mind that this typical picture is seldom seen after the twentieth or twenty-fifth year as the constant process of attrition tends to efface the notch. After the characteristic crescent is lost the teeth are merely shorter and more convergent than they should be.

In addition to the more or less typical lesions of the various stages of syphilis seen by the rhinologist there is another phase of the disease deserving consideration. Systemic syphilis in the absence of local lesions has an important bearing upon the treatment of the nose and sinuses. Persistent over-secretion, post-nasal discharge, nasal obstruction, atrophic rhinitis, hypertrophic rhinitis, hyperplastic rhinitis and sinusitis, polypoid hyperplasia and vasomotor rhinitis may have a syphilitic background. Even in the absence of a positive serologic examination, a therapeutic test may bring about prompt improvement in a condition that has failed to respond to any other treatment.

Many manifestations of syphilis in the nose and mouth should be easily recognized but others can be diagnosed only by deduction and exclusion. The latter will often be overlooked unless the physician is ever syphilis-conscious.

514 Cooper Street

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## INTENSIVE TREATMENT OF SYPHILIS

The five-day ultra-intensive treatment for early syphilis uses Arsenoxide (Mapharsen) by continuous intravenous drip at the rate of 20 mg. of Mapharsen in 200 c.c. of 5 per cent glucose per hour for 12 hours daily on five successive days. This represents 240 mg. of Ma-

pharsen in 2400 c.c. of 5 per cent glucose administered daily, or 1200 mg. (1.2 gm.) of Mapharsen in five days (20 standard 60 mg. doses). A rather high incidence of reactions, some potentially fatal, is reported by Loren W. Shaffer, in *The Journal of the Michigan State Medical Society*, July, 1941.

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## INCREASING BISMUTH EFFICIENCY

The effectiveness of bismuth as an antiluetic drug was found enormously increased by using vitamin C as a vehicle, according to a recent report by S. L. Ruskin, M.D., and Miron Silberstein, M.D., in the *Medical Record*. They used bismuth cevitamate, which is a bismuthyl derivative of the sodium salt of ascorbic acid.

It is dissolved, in a one-to-ten glycerol-water mixture, and prepared in ampoules for injection. It was found effective in Wassermann-fast cases, as well as in early syphilis. The therapeutic index of bismuth cevitamate was calculated as 33. as compared with 12.5 for potassium-bismuth-tartrate in oil suspension.



## OSTEOMYELITIS OF SKULL \*

By RAPHAEL POMERANZ, M.D., Newark, N. J.

Osteomyelitis of skull is a most serious condition. It therefore becomes a great responsibility of the roentgenologist in making an earliest diagnosis possible or in helping the surgeon to decide the most appropriate method of procedure in a particular case, even by a negative report. The fulminating type of osteomyelitis is rare in our locality, being much more common in other places (Boston). Cases which persist for a longer time and become subacute or chronic conditions are definitely a problem for the roentgenologist. It is from the latter group that I wish to report two cases, one complicated by diabetes and treated by means of chemotherapy with good recovery, the other one complicated by tuberculosis, and treated surgically. The latter case came to autopsy.

The number of cranial osteomyelitis cases encountered in hospitals and in private practice is at present small. This fact is due to modern aseptic, antiseptic, and prophylactic methods of treatment of the most common post-traumatic causes of osteomyelitis. The number probably can be further reduced by means of chemotherapy.

### PATHOLOGY

Fuerstenberg,<sup>1</sup> Mosher,<sup>2</sup> Macmillan,<sup>3</sup> and McKenzie<sup>4</sup> contributed most to the understanding of the pathology of cranial osteomyelitis. Cranial osteomyelitis may either be localized or of the spreading fulminating type. Either type may arise by continuity from an infection of the paranasal sinuses, mainly the frontal sinus, or a mastoiditis, petrositis, or be secondary to a primary infectious focus elsewhere, or may follow a direct trauma to the soft parts with secondary bone invasion. The most common localization of the disease is in

the frontal bone, next come the temporo-parietal bones, and the occipital bone.

The diploe of a flat bone of the skull can only, in principle, be compared with the medullary cavity of a long bone. This is evident from the structure of the diploe which reveals large spaces for the diploetic veins. They are very numerous and connect superficially with the veins of the scalp. The diploetic veins also have deep connections with the blood sinuses of the skull. In addition, the diploetic veins of the frontal bone are large and extend as direct continuation of the veins of the mucous membrane of frontal sinus. Infection causes a thrombophlebitis of the veins of the mucous membrane, which by retrograde thrombosis extends into the diploetic veins of the frontal bone. The virulence of the infection and the resistance of the host decide the progress of the disease and the ultimate fate of the patient.

Mosher revealed by extensive and systematic study of the removed specimens of osteomyelitic bone, important facts necessary for understanding the spread of the disease. The frontal bone is commonly involved and contains two kinds of bone marrow; the yellow or fat marrow, and the red or blood-forming marrow. The yellow marrow contains a large number of fat cells separated from each other by narrow stellate spaces. The cells lining these stellate spaces are capable of great activity in the production of fibrous tissue. The red bone marrow contains all kinds of blood cells at various stages of development. The diploetic veins are found in both fat and red marrow.

Mosher further revealed that the changes occurring in the bone marrow which is infected usually occur in definite order. The veins enlarge greatly and often break causing hemorrhage. Almost at the same time a protective fibrosis begins in the yellow and the red marrow. If the infection is more severe and overwhelms the protective fibrosis, patches of bone die and form sequestra, around which the osteoblasts try to produce new bone.

The most important clinical symptom is the

\* Read before the Section on Radiology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 22, 1942.

1. Fuerstenberg, A. C.: Transactions of the Pacific Coast Otc-Ophthalmological Society, 21:111.
2. Mosher, H. P.: J. A. M. A., 115:1179. 1941.
3. Macmillan, M. S.: J. A. M. A., 115:1169. 1941.
4. McKenzie, D.: Diffuse Osteomyelitis from Nasal Sinus Suppuration, Laryng. Rhin. & Otol., 28:6, 1913. Further observations on spreading osteomyelitis of the skull, *ibid.*, 42:293. 1927.

pitting edema of the forehead, Pott's puffy tumor. The limit of the edema is a practical guide to the limits of the infection in the bone marrow. When clinical findings are correlated with the x-ray evidence and with the removed osteomyelitic bone one should remember that, microscopically, the disease is shown to extend one or two inches above the limits shown in the x-ray evidence of destroyed bone.

#### ROENTGENOLOGIC EVIDENCE

The technic for visualization of the diseased bone should conform with the type and location of the disease. If the frontal bone is involved, four views of the sinuses are necessary. In addition, in the spreading fulminating osteomyelitis, one should take tangential views with the soft-structure technic. This is of particular importance when one attempts to discover early signs of bone erosion: the small perforations in the diploe corresponding with the pathways of the infection as above described. One must remember, however that many of the earliest signs of changes in density, and bone erosion may appear only after seven to ten days—too late for the surgeon. He must decide beforehand on the method of procedure. The negative x-ray findings are also of assistance to the surgeon if he decides to operate. The x-rays disclose the type and thickness of the bone, the depth of the sinuses, the number and appearance of the vascular structures. In the fulminating osteomyelitis, Mosher and others advocate radical surgical procedure; removal of the bone one to two inches beyond the area of the diseased bone, and if necessary, removal of the entire frontal bone. In cases where the infection has lasted for several weeks, the x-ray evidence as a rule is clear. Two standard views and one tangential soft-structure view are sufficient. One can see an area of rarefied bone, with or without sequestra. If the case improves under local and general treatment, a gradual sclerosis of the bone takes place, particularly at the borders of the infected area.

#### COMPLICATIONS

The complications of a cranial osteomyelitis are very serious as compared with the infection of a long bone. This is due to the fact

that the dura and the brain are neighbors to the diseased bone; therefore, sub-dural abscesses meningitis and brain abscess are the common complications of the disease.

#### REPORT OF CASES

These cases are reported through the courtesy of the Head Service of the Newark City Hospital.

*Case 1:* S. S., colored, male, 39. Admitted to the hospital July 10, 1941. Four weeks prior to admission patient sustained an injury to the right chest wall following which an infection of the soft parts developed. X-ray examination on July 27, 1941, showed no evidence of fractured ribs or bone erosion. Lungs were negative for tuberculosis. Sputum was negative for tubercle bacilli. Wassermann and Kahn were negative. Blood and urine showed evidence of sugar: glucose 4 plus, acetone 3 plus. The mass on the right chest wall was incised; the pus evacuated contained staphylococci and diplococci. The wound healed well. Patient was referred to diabetic clinic for further treatment. Patient was readmitted on September 10, 1941, with a painful swelling of the occipital region and of the right temporal region. He complained of headaches and dizzy spells. X-ray examination on September 11, 1941, showed evidence of osteomyelitis of occipital and right temporoparietal bones. Temperature was running up to 101. Beginning November 1, 1941, pus was aspirated from both areas of infection, and ten to twenty grams of sulfathiazol were injected. The procedure was repeated weekly; six in all. Patient steadily improved and was discharged on February 12, 1942, for follow-up to the diabetic clinic. Blood sugar on December 6, 1941, was 0.187. Sulfathiazol determination in blood was 2. mg. per cent. Patient was in good clinical condition when discharged.

*Case 2:* McK. B., colored male, 46. Admitted to Newark City Hospital on March 23, 1941, with a painful swelling in the occipital region of two months' duration which has followed a minor laceration of scalp. X-ray examination on March 31, 1941, showed evidence of early bone lesion of the outer table of occipital bone. The carbuncle was incised and patient discharged improved. Patient was readmitted on June 18, 1941, with a diagnosis of Pott's puffy tumor. Patient also had symptoms of brain complication. X-ray examination now showed evidence of soft structure infiltration in occipital region with advanced bone erosion. Wassermann was negative. The pus from the carbuncle of July 9, 1941, contained streptococci and diplococci. Patient died on August 16, 1941. Summary of autopsy: Dr. H. S. Martland. Fibrous tuberculosis of left upper lobe containing two small cavities. Caseating tuberculosis of the left hilar glands. Tuberculous osteomyelitis of the occipital bone. Extradural tuberculoma. Cerebellar tuberculoma. The entire brain showed marked edema of the piaarachnoid and of the parenchyma with dilatation of lateral ventricles. The left temporo-sphenoidal

lobe showed a patch of indurated dura containing a number of tubercles. The left cerebellar hemisphere in the middle line contained a large granulo-matous mass,  $2\frac{1}{2}$  inches in width. Another smaller one about 1 cm. in diameter was located deeply in the parenchyma of cerebellum.

#### COMMENT

*Case 1* represents an example of a localized, metastatic type of osteomyelitis in a diabetic. Because of the diabetes the surgeon decided to treat the case conservatively; by means of aspiration of pus and local installation of the sulfothiazol. The review of the literature disclosed some cases treated by means of chemotherapy with good results. The standard diabetic diet was also of material help. It is interesting to note that the roentgen revealed defects persist after several months following the clinical recovery.

*Case 2* is an example of a post-traumatic osteomyelitis complicated by tuberculosis. The severe soft structure infection caused a retrograde thrombophlebitis which in turn has

caused the bone destruction. One may theorize on the question as to whether the tuberculous brain lesions have spread with the infection or if these lesions were dormant prior to the trauma and infection. We know from other cases that floating tuberculosis bacilli may localize in an area after a trauma and more so when combined with infection.

I believe that in properly selected cases, a combination of chemotherapy and small doses of radiation may be tried. The x-rays will help to detoxify the patient and to diminish the edema.

#### SUMMARY

General pathology and x-ray evidence in cranial osteomyelitis was discussed. One case of localized metastatic osteomyelitis in a diabetic was reported, with recovery after local application of sulfothiazol. Another case of post-traumatic occipital osteomyelitis, complicated by tuberculosis, was reported with autopsy findings.

31 Lincoln Park

### FUND DONATIONS TO HEALTH IN 1940

Medicine and public health continue to rank first, although education runs a close second, among the objects towards which American foundations now grant an annual total of \$40,400,000, according to a survey of foundation giving issued by Raymond Rich Associates, 330 West 42nd Street, New York City, consultants to nonprofit organizations. The survey, embracing reports from 314 leading foundations, brings up to date a similar survey of 243 foundations published in 1939, and earlier investigations prepared by the Twentieth Century Fund.

The survey indicates that for medical research, medical education, the erection and support of hospitals, and other purposes related to medicine and public health, foundations granted individuals and institutions 30.4 per cent of their total disbursements, or \$12,273,590 during 1940, the latest year for which complete figures are available.

Education, the foremost concern of foundations until outranked by medicine and public health as indicated by the 1939 survey, now appears to be receiving almost equal support. During 1940 \$11,696,605 was given to general education, or 29 per cent of the total gifts.

The other leading fields in which foundations subsidize projects are, in the order of volume grants: social welfare, \$4,395,898; the physical and biological sciences, \$3,783,643; social sciences, \$1,528,510; religion, \$1,224,044; and government and public administration, \$1,062,917.

In bringing together these and other figures covering foundation activities and structures, the Rich organization restricted its report to foundations that paid out at least \$1,500 during 1940 *for projects not directly controlled by foundation staff members*. Previous surveys provide comparable figures for 1937, 1934 and 1931.

Although the grants of several large foundations provided an important part of the subsidies for medical and public health projects, gifts over one million dollars in 1940 accounted for only 56 per cent of the total grants in this field as compared with the 1937 gifts of over one million dollars, which accounted for 79 per cent of the total for that year. However, the smaller foundations have devoted an increasingly larger share of their income to medical research, thus making up the difference.



# ANGINAL PAIN DUE TO ADHESIVE PERICARDITIS

(FOLLOW-UP ON A CASE REPORT IN THE SEPTEMBER, 1936, JOURNAL,  
PAGE 535)

By LOUIS A. EIGEN, M.D., and ARTHUR R. ABEL, M.D., West Orange, N. J.

From the Department of Pediatrics (Dr. Eigen) and the Department of Pathology (Dr. Abel) of the Orange Memorial Hospital, Orange, N. J.

This patient was previously reported in a paper titled "A Syndrome Resembling Angina Pectoris", published in the *Journal of The Medical Society of New Jersey* of September, 1936. This patient was so unique from a clinical point of view that we thought it worth while to follow and examine her quite frequently. She was under our very close observation from 1933 until her death in February, 1942.

We are now presenting a follow-up report chiefly because of the fact that an autopsy was done and because it is always illuminating and informative to correlate pathology with clinical signs and symptoms. In this case we present our autopsy findings which we believe will be instructive and explain much of the clinical findings.

In our original report we described the onset of the paroxysmal cardiac pain which followed rheumatic heart disease which the patient suffered at the age of six. This pain was associated with a period of syncope accompanied by sweating, flushing and blanching of the face. Since the onset of her disease she has had recurrent attacks of pain which increased in number and severity. The attacks seemed to be precipitated by physical exertion or by an emotional upset. They came on, from ten minutes to several hours after the physical or emotional strain. Some of these attacks came on while the patient was asleep. These attacks had necessitated, on several occasions, admission to the hospital for treatment.

Her last admission was on January 24th, 1942. She was then 17 years old. A month before she had developed a cold with associated severe coughing. Three days before admission to the hospital she complained of a pain in her shoulders. The cough was persistent and at times she coughed up a few drops of blood. Her temperature was 101.2 F., pulse 95, respirations 40. Examination showed changes in the bases of the lungs suggestive of

bronchopneumonia. These findings were substantiated by roentgenogram. The roentgenogram also revealed that the heart was definitely larger than on a previous admission in 1938. Her urine contained a trace of albumin. The erythrocytes were 3,600,000, hemoglobin 78 per cent. There were 28,000 leukocytes, 90 per cent of which were neutrophils. The sedimentation rate was rapid, being 35 mm. in 30 minutes by the Cutler method. The Kolmer Wassermann was negative. Medical treatment, which included administration of digitalis, acetylsalicylic acid and codeine, was unavailing. She failed gradually and died on the 15th day after admission.

## AUTOPSY

(PERFORMED 6 HOURS AFTER DEATH)

*Gross:* The body was that of a white girl of 17 years. No external lymphadenopathy was present. The chest was elongated and flattened, the ribs extending well down over the liver area.

*Abdomen*—The liver was moderately enlarged (by congestion), extending about three fingers below the costal arch. The spleen was slightly enlarged (8 by 8 by 12 cm.). It was unusually firm and had a smooth capsule. The cut surface was smooth and mahogany red in color. The gastro-intestinal tract was negative throughout. The pelvis contained about 200 cc. of straw-colored fluid. The uterus and adnexa were normal. The kidneys showed little gross change. The suprenals were normal in size and appearance.

*Thorax*—The right lung had numerous adhesions over the lower lobe especially on the diaphragmatic surface. The left lung was free and clear. Both apices were well aerated, showing no old scars or adhesions. The lower lobes of both lungs showed a complete consolidation. This also involved a portion of the middle lobe of the right lung. On cross-section the lung was solid with many small circumscribed areas

of greyish-white necrosis. These averaged less than 1 cm. in diameter and were irregular in outline. At their borders there was a distinct change in color to the reddish brown of the surrounding lung tissue. No cavities or abscesses were seen anywhere in the lung.

The heart was enlarged, measuring 12 by 14 by 18 cm. The enlargement was chiefly right-sided. The heart was densely adherent to the pericardium over almost its entire surface. These adhesions were firm and fibrous with no evidence of recent exudate. The myocardium was thickened and seemed to cut with increased resistance. The color was reddish brown. The valves of the heart showed no vegetations. The pulmonary and tricuspid valves were slightly enlarged but the cusps were thin and delicate. The mitral valve was contracted and fibrous, resulting in a loss of normal flexibility. The cusps of the aortic valve showed contracted fibrous borders. The free border was rolled over or lipped, resulting in some loss of normal motility. The coronary orifices were patent. Dissection of the coronary arteries showed no narrowing or calcification. The aortic arch was smooth but the surface showed irregular yellow plaques. These were not contracted or wrinkled. The aorta did not appear to be dilated.

#### *Microscopic:*

*Liver*—Sections showed extensive passive congestion associated with fatty infiltration of many of the liver cells. This change was most pronounced in the region of the portal vein. The general structure was well preserved.

*Spleen*—The splenic pulp was compact and cellular. The sinuses contained little blood. The malpighian corpuscles were large and fibrotic.

*Kidney*—The sections showed only cloudy swelling of the cells in the tubules with swelling and congestion of the glomeruli.

*Adrenals*—No pathological changes were seen.

*Heart*—The cardiac muscle was degenerated and fragmented. There was considerable diffuse fibrosis between the muscle bundles. No Aschoff bodies were seen, but there were collections of round cells in many areas.

*Lungs*—These showed an unusual type of inflammatory reaction. The alveoli were filled with inflammatory cells and secretion. Their walls were thickened by an infiltration of neutrophils, lymphocytes and eosinophiles. This process was associated with widespread necrosis. The areas involved were scattered and well circumscribed with surrounding congestion and edema. This was not a tuberculous process but rather an unusual type of pneumonic consolidation, following prolonged passive congestion.

#### Pathological diagnosis:

1. Adhesive pericarditis.
2. Chronic myocarditis.
3. Mitral stenosis.
4. Passive congestion of lungs.
5. Passive congestion of liver.

#### DISCUSSION AND CONCLUSION

In view of the autopsy findings we are justified in assuming that the angina-like pain suffered by this patient was the result of the adhesive pericarditis. The adhesions between the heart and pericardium were unusually firm and fibrous and must have been present for a long time. The supposition is that they were formed at the time of her original rheumatic attack at the age of six. It would seem that the mechanism resulting in the pain was that of myocardial fatigue rather than interruption of the blood supply. The coronary arteries showed no evidence of occlusion and even widespread pericarditis should not cause any interruption of the blood supply to the heart muscle. Myocardial damage was present but this was of a type usually seen following rheumatic fever.

The recent respiratory infection probably precipitated the terminal attack.

511 Valley Road

THE PATIENT'S OWN DESCRIPTION OF HIS present illness will be much more valuable to the doctor if recorded as largely as possible in the patient's own words, which should always be enclosed between quotation marks. Usually a simple phrase

used by the patient in describing a symptom will project a clearer picture than will a paragraph of the doctor's description—"Disease and the Man"—Lapham.

## CASE OF "ARGYRIA" IN YOUNG FEMALE DUE TO OVERADMINISTRATION OF A COLLOIDAL SILVER PREPARATION

By MILTON H. GORDON, M.D., Camden, N. J.

With the ever-increasing number of colloidal silver preparations being put on the market, it seems worthwhile to bring this case before the medical profession as a reminder of a possible disfiguring complication due to use of a common therapeutic agent.

*Report of Case:* G. K., age 12, a white school-girl, had been in a generally good state of health throughout her life, with the exception of measles and mumps in childhood. Her only complaint was a bluish discoloration of her sclera, skin of her face, neck, hands, and fingernails, and to some extent, toenails. This had been present for about a year and was gradually becoming worse.

The past history revealed that in November, 1939, following a series of "head colds", the patient was taken to a physician who made a diagnosis of "sinus trouble". A common colloidal silver preparation was prescribed in the form of nose drops for daily use. The patient received in addition local treatment of the nasal mucous membrane with tampons of the same silver preparation at various occasions for about a year. After local treatment was stopped, the patient continued the drops almost daily until seen by me, on November 21, 1941. The patient came to me believing she had "heart trouble".

Physical examination revealed a well-developed 12-year-old white female whose only

complaint was a bluish discoloration of her skin.

Her face and sclera had a metallic lead or bluish gray color. This discoloration was most marked around the nose and mouth. However, the discoloration first appeared in the sclera. The neck, arms, fingernails, and toenails were less affected. The back, chest and abdomen were definitely less affected but probably not normal color.

The remainder of the physical examination was entirely negative. Laboratory studies: Blood count and urine analysis were normal. Electrocardiographic study and fluoroscopy of the heart and lungs were entirely negative.

*Summary:* After a review of the literature on this subject, it is apparent that the only way to avoid this irreversible complication is to restrict the use of silver compounds. The number of cases reported developing under medical supervision indicates that physicians are not always conscious of the danger. Lay people have no idea whatsoever of this possibility, and the indiscriminate sale and use of these drugs should be controlled, at least by a warning label on the bottle.

It is to be noted also that exposure to sunlight has a tendency to fix the silver in the tissues. This should be remembered particularly in individuals under somewhat prolonged colloidal silver therapy who may be exposed to sunlight for long periods of time.

12 North 27th Street

### SIMULTANEOUS IMMUNIZATION AGAINST DIPHTHERIA AND WHOOPING COUGH

Readers of this *Journal* will recall an article in the September, 1941, issue (page 461) by Simon and Craster on simultaneous immunization against diphtheria and whooping cough. The preparation they used is now available commercially as "Diphtheria Toxoid Alum Precipitated-Whooping Cough Vaccine-Combined"—Squibb. Each cubic centimeter of the combination product contains a full immunizing dose of Diphtheria Toxoid Alum Precipitated and 10,000 million killed bacillus (*hemophilus*) pertussis.

This new product possesses the advantage of convenience and economy. Reactions to the com-

bined antigens are apparently no more frequent or severe than those following the use of diphtheria toxoid alum precipitated.

To be on the safe side, it is suggested for the present that three or four injections of 1 cc. each of the combined vaccine be given at monthly intervals. This will confer a high degree of immunity to diphtheria and should afford adequate protection against whooping cough. Immunization is recommended for all children over six months of age.

Diphtheria Toxoid Alum Precipitated—Whooping Cough Vaccine Combined is supplied in 5 cc. vials containing sufficient vaccine for five injections.



**FACT, FUNCTIONAL OR FAKE \*****THE NEUROPSYCHIATRIC PROBLEM OF THE ARMY**

By MAJOR JAMES A. BRUSSEL, Medical Corps, U. S. A., Chief Neuropsychiatrist,  
Station Hospital, Fort Dix, N. J.

In the past few and swiftly moving months, the entire population of this country, professional and non-professional, military and non-military, has finally realized the importance of psychiatric consideration in the matter of selecting the men for our armed forces. More, this consideration has wisely become a preventive item rather than the inevitable cure. One neglected psychiatric disorder in a member of the Armed Forces, unforgivingly passed by some careless examiner with casual indifference, might bring disaster upon every citizen of this country whose freedom and democracy he is supposed to be defending. For example, let us consider the young man who has been drafted. Superficial examination of his past history reveals what is so quaintly termed "essentially negative" by many physicians. But honestly, essentially negative is not completely negative. He has been a brilliant student; in fact, he has "buried himself in his books". There were no outside interests, hobbies or associations. He admits that he has never mingled well, and is shy and retiring. This same young man with his inability to make contacts with reality is soon the butt of scornful remarks in the barracks. He withdraws into himself, becomes increasingly seclusive, brooding and asocial. Failing to recognize his own deficiency, he resorts to a projection method of rationalizing his difficulties and gradually is convinced that his comrades in arms are "against him". Later, he may say they are "plotting against him" and "trying to frame him" because they are jealous of his superior intelligence. It is obvious that a full-blown paranoid form of schizophrenia is well on its way to clinical completion. This man can serve no useful purpose in the military, and becomes a medical burden to the Army

and to the citizenry who, as taxpayers, bear the expense.

Let us consider another draft candidate. His past history, too, is negative, except that in his childhood, until he was fourteen, he had occasional "fits". His description of these seizures more than suggests a grand mal pattern. Close questioning reveals that since the age of fourteen he has never had a convulsive attack and now, at the age of twenty-five, he appears to be in perfect health. The examining physician therefore passes him. The individual becomes a soldier, and is placed, let us say, in the medical department. After months of intensive training his unit is sent to the front. Our soldier has been selected as the contact man who in battle orients the aid station commander and the collecting station commander with each other's location. This is a very important position, carried out by one man alone. If he becomes lost, if he cannot locate the aid station, thousands of wounded soldiers may die because the chain of medical care has been broken at what is admittedly its weakest link. Our soldier, however, is adept at noting features of the terrain, and is a keen observer. In his first battle—his baptism of fire—he is deep in some wooded area running to the aid station. Planes are droning over head; the roar of artillery, the screams of explosives, all fill his ears. He is unafraid, but some inner tension is mounting, some demand for unconscious relief that his ego structure remembers could only be found in one way a dozen years previously. Ergo, he has a grand mal seizure, and falling to the ground with no one to see or help him, unfortunately goes into a status epilepticus and dies. At a meeting in New York a year ago, held for physicians doing draft work, one doctor asked what he should do with one draftee. This man had a clear history of grand mal up to the age of ten and thereafter no attacks. All of the Army neuropsychiatrists present

\* Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, April 22, 1942. Approved for publication by the Surgeon General of the United States Army.

agreed that such a person should be rejected, for we have seen too many similar examples who, faced with the new life and a new threat from reality, return to their former and almost forgotten epileptic way of life.

These are all isolated examples I have given to you, presenting a problem that is best combatted by careful weeding out, and requires co-operation of the physician, social agencies, hospitals, clinics and the general laity. There will, however, arise another problem in the military circle that is a challenge to the neuropsychiatrists's diagnostic ability. The situation I have in mind is best delineated again by example.

Let us consider a soldier who reports one morning to his regimental medical station at sick call. His face is distorted with pain, every line in his face bespeaks his anxiety and agony. He is clutching at his chest and is dyspneic. He is perspiring profusely and almost fails to find the strength with which to describe his illness. He gasps out that he has a stabbing pain "here", pointing to his cardium, and that he "can't go on any longer". The man appears acutely ill. The surgeon quickly applies the stethoscope and finds that, aside from a tachycardia, cardiac examination is negative, or, perhaps, there is a murmur present which was correctly regarded at the time of induction as "functional" or "haemic". The soldier is then sent to the station hospital for admission.

The problem now becomes one of differential diagnosis. In the station hospital he is given a complete and most careful physical examination which includes, in addition to the routine laboratory and clinical procedures, an x-ray of his chest and an electro-cardiogram. A definite endocarditis is discovered with all the clinical and physical findings accompanying such a picture. Obviously, the soldier has organic heart disease and steps are taken to discharge him from the Army because of physical disability. The case is clear-cut.

However, let us consider a second soldier who duplicates in every detail the picture given above, except that his murmur is functional and there are no clinical or laboratory evidences of cardiac disease. That he is suffering, that he is in pain and markedly dyspneic is obvious. The nurse in her morning report re-

cords the facts that the patient had two dizzy spells and fainted on one occasion. A psychiatric consultation is requested. The following history is elicited. Father is living and well. Mother is an invalid who must watch every move she makes with extreme caution because she suffers with "heart trouble". We do not know if this ailment is real or imaginary; but it is, nevertheless, recorded as "heart trouble". The patient has never been away from home. His mother always took particular care with his meals and did everything to shield him from the dangers of life and to make him comfortable. He mingles well with his barracks mates, but is never so happy as the times when a letter or package arrives from home. He states that he has never had these symptoms before he came into the Army, but shortly after his arrival at the recruit reception center he began to notice that pains around his heart were interfering with his work. Not severe at first, but increasing gradually in intensity.

He also mentions headaches, dizziness, syncope attacks, dyspnea, cardiac distress, palpitation—palpitation that causes him to sit up at night in sheer fright. He also notices that he has gastric discomfort ever since he began eating food his mother didn't cook. He has belching, gas, constipation, and a gnawing sensation in the pit of his abdomen. The examiner notes the patient's anxiety, apprehension, and preoccupation with somatic complaints. Further questioning reveals that the soldier is often depressed—he says "sad"—and that when he thinks of "Mother home alone and so critically ill, he bursts into tears".

This, then, is a product of environmental over-solicitude. An unwholesome maternal attachment that breeds an oedipus situation which has no solution. The demands of this attachment and the demands of reality to form a heterosexual adjustment lead to a mental conflict that is answerless. The ego, therefore, accepts a compensation in a somatic outlet which simultaneously incorporates the mother. That is, emotional conflict finds expression in physical symptoms. It is the unconscious way of saying to reality, "You see? I cannot cope with your requirements. I am too ill. I am suffering with the same sickness that my

mother has." The symptoms are necessary for the patient to keep himself at least superficially adjusted to a heterosexual level.

They are not "imaginary". They are real, the suffering is as intense as if violent organic disease were present. Nor can this patient be relieved by telling him he has no heart disease. You can't knock the props from under his flimsy platform of adjustment with those few words. He knows he *must* have a severe organic illness because his symptoms are the same as his mother's—and she is an invalid under constant medical supervision. What treatment is indicated for this soldier? The diagnosis is psychoneurosis (anxiety state and conversion hysteria). His one hope is a course of psychoanalysis. The army is not equipped to administer this, nor would it want to be, since it requires individual attention for an hour a day, five days a week. The entire course may take two years. Therefore, this soldier, too, is discharged on a Certificate of Disability for Discharge.

And then, we have the third soldier. He is admitted to the hospital with the same story and the same symptoms. His physical examination is completely negative. Again, the patient is referred to the psychiatrist. This patient's history is interesting and highly significant. He is either sullen, reticent and suspicious, or, perhaps, more than eager to impress the examiner with his symptoms. He states that he likes Army life, except that certain types of work are "too much for him"—make him weak and ill. Questioning reveals that labors such as kitchen police detail, guard duty, and intensive drilling and marching are particular offenders to his physical well-being. He admits that he has been arrested, in civilian life, a few times: Once for disturbing the peace (when he was drunk), another time for "having a car that didn't belong to him" (a picturesque cloaking of the exact charge), a third time for "hoboing", and again for "insulting a girl". He airily declares that all charges were dropped because they weren't true. Red Cross investigators usually find the soldier had been given a suspended sentence and admonished to get out of town at once. The charge of vagrancy, however, netted him

30 days in the work house. Yes, he had some trouble with a woman. He was, er, forced to marry a girl somewhere out West—he is quite vague—but doesn't know where she is now. The implication is, that after he "done right by Nell, he deserted her". In the Army he has never been intoxicated more than once a month. The reason for that is due to the fact that pay day comes but once every four weeks. He has been AWOL four times. His explanations for these are nothing less than glorious. Once, he "missed his train coming back", a second time he "was sick and had to stay home an extra day"; a third time "he didn't read his pass right", and the fourth occasion—"well, he doesn't remember". There are no hallucinations or delusions elicited. Sensorium is clear; contact is good. Some relative in his family who actually suffers with organic cardiac disease serves as the pattern after whom our patient models himself. The pain, cardiac distress, dyspnea, and allied symptoms are letter perfect. Knowing his pattern well, the patient cleverly rejects unrelated symptoms suggested by the examiner. He is patently a Psychopathic Personality. More descriptive synonyms have been suggested. The physician politely calls him a malingerer; the layman says fakir; the police label him bum; and the Army murmurs goldbrick!

The subject of goldbricking recalls a humorous aside. Soldiers traveling between the Out-patient Department and the Neuropsychiatric Service have ample time in which to read consultation slips. Therefore, it would be unwise to have these patients discover the diagnosis of "Goldbrick". To avoid this situation, we have invented the term "Brickibus Aureautus". On three occasions, the syndrome was so marked we had to append the words "Maximus et Extremus". For the soldier who is neither a goldbrick or a neuropsychiatric case, but frankly admits "he is frightened by the thought of being shot in the war", we have employed the designation of "Allergica ad Bellum". Decidedly poor Latin, but most useful as clinical camouflage!

And this individual is utterly worthless to the military. Tell him bluntly that he is sham-



ming; throw him out of the hospital. It will avail you nothing. What can we expect of this man under a situation of actual warfare? What reliance can we place on him in the battle field; what responsibility can we hope that he will bear? The Army is not a reform school. We can regard him only with misgiving, distrust and, perhaps, scornful resentment. In a coördinated effort to defend our liberty we cannot risk having such a person within our ranks. He is potential material for foreign agents; he is a breeder of poor morale; he is a parasite and a hindrance. As the horticulturist carefully weeds out all worthless growths, so must this cancer in an otherwise healthy body be completely and promptly eradicated. Hence, he is brought before an Inaptitude Board and ultimately discharged because of "certain traits of character that render him unfit for military duty".

Is there a solution for any one or all of these patients which I have described to you? The answer is not to be found in the Army for the problem is one of prevention rather than cure. Stem the flow from the point of origin. It is not only the duty of the examining physician at the source of entry, but every one of us to assist in this minutely, careful weeding-out process. Every hospital, every institution, every law-enforcement body, every social agency should make it their business to inform the draft bodies of facts or symptoms that may serve as a basis for investigation. It is no longer a question of prying into your neighbor's business. It is simply another demand upon the coöperative spirit of each one of us in our concerted effort to accomplish all that is possible within our means to successfully culminate this war so that democracy and liberty shall not die.

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RECORDS OF 317 CASES OF GUNSHOT wounds of the head have been examined with regard to the occurrence of epilepsy. The period of follow-up varied from about seven to twenty years.

Of the 317 cases, 107 (34 per cent) developed epilepsy. In cases in which the dura had been penetrated fits were twice as frequent (45 per cent) as in the scalp and skull wounds in which the dura was intact (23 per cent). There was no evidence that removal of metallic foreign bodies from the brain diminished the liability to epilepsy. Prolonged wound sepsis, as indicated by delayed healing, favored the subsequent onset of epilepsy both in cases in which the dura had been penetrated and in those in which the integrity of the dura had been preserved. Epilepsy was more common after wounds affecting the sensorimotor cortex than after wounds of the polar regions of the cerebral hemisphere. The presence or absence of concussion (immediate unconsciousness) after gunshot wound did not influence the subsequent liability to epilepsy.

The first fit may occur within a few hours after injury or may be delayed as long as 20 years. Epilepsy begins more often in the first two weeks, and thereafter the liability to develop epilepsy progressively diminishes. In 30 of 96 cases, fits ceased some years before the patient was last examined. This subsidence of epilepsy occurred most often in cases in which fits began in the first fortnight after injury, less frequently when fits began within the first two years, and never when the first fit occurred more than two years after the injury—From: *Traumatic Epilepsy After Gunshot Wounds of the Head*. P. B. Ascroft, M.S., F.R.C.S., Brit. M. J., 739-7. May, 1941.

PAYING, OR NOT PAYING, THE DOCTOR seems to be part of each patient's personal habit-mechanism. One family automatically pays any doctor bill the day it is received; another defers all bills 30 days as a matter of practice. One man would no more think of walking out of the M.D.'s office without paying his fee than he would think of walking out of a restaurant without paying the check. Another man never thinks of paying cash over the desk. And so it goes. Obviously it would be a boon to doctors, if there were some method of promptly pigeon-holing each patient according to his payment-habit-classification.

Perhaps the only way of achieving this desideratum would be for some central agency in each community to collect the experience of doctors and record them according to the names of the patients. Such a procedure might be frowned on as a breach of confidence; but let it be noted that it is taken as a matter of course in all business, where credit rating bureaus thrive on preparing just such data. Medicine, it may be retorted, is not a trade (though the government has ruled that it is). But here, the concern is only with the business, not the scientific side of the profession. Doctors would be asked to list only their business experiences with the patients, not their professional findings. Such a scheme has been in operation since 1937 in the Milwaukee County (Wisc.) Medical Society, where the collection of previously unpaid medical bills averages fifty thousand dollars a year. The agency of the society charged with this work is frankly labelled "The Business Bureau", and it already has data on the doctor-bill paying-habits of over 100,000 patients.

## RUPTURE OF THE UTERUS—A STUDY BASED ON MATERNAL DEATHS IN THE STATE OF NEW JERSEY, 1937-1941 \*

MATERNAL WELFARE ARTICLE NUMBER SEVENTY-TWO

ROBERT R. WHITE, M.D., F.A.C.S., East Orange, N. J.

In every pregnancy there is potential danger of a rupture of the uterus. This is often lost sight of by the attending physician. Consequently, he becomes much alarmed when suddenly confronted with this most dangerous condition, having no preconceived plan of action ready for use. I have often thought that valuable use of leisure moments, when sitting by the fireside or resting in bed, might be profitably spent in solving hypothetical cases of a dangerous nature. To be conscious of potential hazards with well-thought-out plans of action with which to meet them often leads a man to chart his course in emergency almost by instinct. Otherwise valuable time is lost, when every minute counts in saving the lives of mother and child. In the presence of contracted pelvis, transverse presentation, pendulous abdomen, dystocia, previous scars in the uterus, and multiparity, disaster is averted only by anticipating a possible tear in the uterus and by avoiding any treatment that would predispose the uterus to such trauma. This mental approach is intensified by a study of maternal deaths from rupture of the uterus in the State of New Jersey during the past five years, 1937-1941.

Classical information on the subject of ruptured uterus is readily at hand in all textbooks and in many current monographs. A didactic discussion will be avoided in this paper inasmuch as our interest lies chiefly in the application of this knowledge of cause and treatment as practiced in New Jersey. During these five years when live births totalled about 287,600 there are reported 30 deaths due to rupture of the uterus. No figures are available to determine the total number of ruptured uteri. Maternal mortality from this condition universally averages 50 per cent. The indication is, then, that there were in New Jersey only 60-75 cases altogether, a ratio of one ruptured uterus

to 4800 deliveries. But recorded statistics in large centers give a ratio of one to 1200, which leads us to conclude that in New Jersey only one-fourth of all cases of rupture of the uterus are recognized and reported. Perhaps an incomplete rupture is present in some cases of severe postpartum hemorrhage.

Dr. A. W. Bingham, Chairman of the State Maternal Welfare Committee, offered for my study copies of the death certificates and reports of the Field Physicians for the years 1937-1941. Information in these was frequently incomplete, which renders accuracy difficult of tabulation. However, certain facts emerge conspicuously.

Of the 30 cases, 27 were white, three Negro.

Multiparity indicates increased incidence of accidents of labor and implies deterioration of uterine muscle with repeated pregnancies.

Gravida I—Five deaths from ruptured uterus.

Gravida II—Six deaths from ruptured uterus.

Gravida III-XII—Nineteen deaths from ruptured uterus.

Apparently 28 out of the 30 were caused by some form of trauma, only two being reported as spontaneous rupture without labor or intervention. This incidence follows universal experience, i. e., spontaneous rupture is rare.

Dystocia was present in 22, or more than two-thirds of the cases.

Long, or violent short labor occurred 16 times.

Rupture of previous Caesarian scar occurred 5 times.

Previous curettage occurred 1 time.

Transverse presentation occurred 5 times.

Breech presentation occurred 2 times.

Bandl's Ring occurred 1 time.

Undilated cervix occurred 1 time.

Eclamptic convulsion occurred 1 time.

Fibroid occurred 1 time.

Large baby with impacted shoulders occurred 1 time.

In the face of these predisposing conditions various procedures were attempted during which rupture occurred.

\* Read before the Section on Obstetrics and Gynecology at the Annual Meeting of The Medical Society of New Jersey, in Atlantic City, on April 22, 1942.

Some form of traumatic delivery .....	23
Version alone .....	6
Forceps .....	2
Failure to deliver by forceps .....	2
Version after forceps failure .....	4
(Total cases when version was used—10)	
Delivery of transverse presentation .....	5
Delivery of a macerated foetus .....	2

Classical treatment is hysterectomy, or suture of the laceration if non-septic or incomplete. Of these 30 cases 20 received no surgery whatever. Of the remaining 10, 5 were delivered by classical Caesarian section with suture of the laceration, 3 were delivered by Caesarian section followed by hysterectomy, and in 2 hysterectomy was done following delivery from below.

Death occurred at varying intervals after rupture in cases without active surgical treatment:

- 2 died undelivered
- 5 died on the table directly after delivery
- 3 died within an hour after delivery
- 9 died within 10 hours. (Valuable time was lost by not instituting active surgical treatment. Procrastination only courts disaster.)
- 7 died from 1½ days to 8 days postpartum. In this group sepsis was the secondary cause of death.

Only 9 autopsies were obtained, and of these the rupture had not been diagnosed in 7 cases.

Shall we review here the signs and symptoms pointing to rupture of the uterus?

#### Of Impending Rupture:

1. Prolonged labor with progressively violent pains.
2. Acceleration of the pulse rate and sometimes elevation of the temperature.
3. Ascent of the contraction ring toward the umbilicus.
4. Exquisite abdominal tenderness.
5. Excessive tension of the round ligaments.
6. Anxious facial expression depicting an excessive degree of suffering.
7. Swelling and discoloration of the pinched vaginal portion of the uterus.
8. Gradual rise of the fetal heartbeat indicating fetal distress.

#### Of Actual Rupture:

1. Lancinating pain followed by:
2. Cessation of uterine contractions.
3. Shock.
4. Bleeding, external and internal, depending on location and degree of the rupture.

5. Change in contour of abdominal mass, accompanied by
6. Palpation of the baby directly beneath the abdominal wall with startling ease.
7. Recession of the presenting part from the pelvic brim.

Prognosis for the baby is extremely bad, but in this series 5 were delivered alive due to the fact that rupture occurred during delivery 21 times. Two were undelivered, and the rest, 23, were stillborn.

#### COMMENTS AS TO TREATMENT

##### 1. PROPHYLAXIS

The most important factor in the treatment of uterine rupture is the prevention of its occurrence. We feel that in most of the reviewed cases rupture could have been avoided. The first pointed lesson to be learned therefore is to give our patients better prenatal care. It stands to reason that good care should maintain or even improve the general health of every pregnant woman. One in good health will be less likely to arrive at a state where rupture of the uterus is possible. A pregnant woman faces inevitably the rigors of an athletic event. She should be trained for it so that her fighting forces and recuperative powers are at top-notch efficiency. Women must be educated to take advantage of the excellent prenatal care that is offered throughout the State. This is one of the largest factors in the prevention of any of the major calamities which may complicate childbirth.

Painstaking and frequent examination of the patient nearing term is mandatory in order to prognosticate possible cephalo-pelvic disproportion or any condition which may cause dystocia. We should be reminded that mere external pelvic measurements are of little value, practically, when it comes to determining whether a certain-sized head will come through a certain-sized birth canal. Internal measurements are essential, and, if doubt exists roentgenographic pelvimetry will save lives. The x-ray men have shown us the common narrowing of the midpelvis between the ischial spines beyond which too large a head will not pass. Even though the vertex lies at the level of these spines and by that circumstance the head should be safely engaged, we must not rest



too comfortably on the old teaching that a successful pelvic delivery is assured. A prolonged labor in this situation may draw down the lower uterine segment to the danger point which threatens the integrity of the uterus. It perhaps requires greater art to extract a baby through a tight pelvis than to go in from above. However, better reasoning and deduction are evidenced by sectioning such patients as well as those with other malpositions.

After adequate evaluation of existing condition, abdominal delivery should be done promptly lest persistence in the practice of our cherished art lead to loss of life. This Caesarian section should be cervical rather than classical, since scars in the lower uterine segment rupture less frequently in subsequent pregnancies.

During labor closer and more acute observation must be applied to detect lack of progress and the reason therefore. A labor, especially in the presence of ruptured membranes, must not be allowed to progress beyond a point when Caesarian section may safely be attempted. Thereafter, sharply rising morbidity and mortality prohibit the use of any Caesarian except extra-peritoneal types. Classical sections performed after six hours of labor with ruptured membranes are too great a risk.

The advantage of early consultation at the development of any abnormality cannot be too strongly urged. Injudicious or ill-timed interference simply adds to the burden of an already overtaxed organism. According to statistics compiled carefully by the Maternal Welfare Committee, accidents occurring in labor happen less frequently in the country than in urban centers of New Jersey. Is this not partly due to the fact that the city practitioner is too busy to give his patients sufficient bedside observation? Depending on the nurse to watch his case, he experiences a false sense of security and, pressed for time, may yield to the temptation to complete the case prematurely. Whereas the country doctor, lacking nursing and operating room facilities, is likely to sit with his patient until completion with the least possible interference.

Delivery should be done as gently and smoothly as possible. Traumatic deliveries were

responsible for 23 ruptures in this series. Version accounted for 10 ruptures. This is a procedure which sometimes nicely solves a difficult problem and is dramatic; yet it should be viewed with greater apprehension than any other obstetrical operation. Stand in awe of a version! Too many are attempted. Version after failure to deliver by forceps is particularly fatal, because the cervix or lower uterine segment may have been damaged already, and most ruptures from trauma are found in the lower uterine segment. The usual cause of dystocia is a contracted pelvis where version has no place. Neither should it be attempted in a dry or contracted uterus; Caesarian should have been done long before. Version is wrong when the baby is dead; craniotomy is the correct procedure. In a neglected transverse presentation version is most certain to rupture the uterus in the thinned-out lower segment due to the difficulty of displacing the head from the pelvis and passing the hand through the contraction ring. The correct operation under these circumstances is decapitation with the blunt hook. Delivery is accomplished by traction on the arm with a hand over the neck to prevent damage to maternal tissue, followed by extraction of the head by the Wiegand-Martin manoeuvre, or if this fails, by craniotomy. Remember that if rupture occurs before the baby is delivered the fetal mortality is practically 100 per cent.

The use of pituitrin is condemned in the first two stages of labor with one exception. If the head is on the perineum and the contractions diminish, only one or two minims of pituitrin may be given. It is understood that the patient is on the table draped for delivery, operator and anesthetist in their respective positions ready for action in case of a tetanic uterine contraction.

The patient who has had a previous Caesarian section should be constantly kept in mind from the seventh month on. When a pelvic anomaly or overdistention of the uterus is found, or if infection after a previous Caesarian is suspected, the patient is not allowed to go into labor. Abdominal delivery is done a few days before the arrival of term date. If she is granted labor, she is held under con-

stant observation throughout. The attending physician must be *in* the hospital, the operating room advised of the presence of such a labor in progress, and a team held in readiness to scrub at a moment's notice. Immediate proper surgical treatment for spontaneous rupture of a previous Caesarian scar renders the prognosis fairly good. Rupture occurs more often following the classical operation than the cervical.

## 2. ACTIVE TREATMENT

a. Impending Rupture — When lack of progress is found in a prolonged labor, suspicion must always fall on the thin and stretched-out lower uterine segment. Operative interference in a hospital is imperative before rupture occurs. Low Caesarian section, or the extra-peritoneal type, if infection is expected, should be the method of delivery especially if the presenting part is unengaged.

After any traumatic delivery or postpartum hemorrhage, manual exploration of the interior of the vagina, cervix and uterus should not be omitted, to detect a rupture which otherwise might be overlooked.

b. Actual Rupture—In the event of rupture, active surgical treatment must be instituted immediately. According to indications, shock must be treated promptly and continuously during the laparotomy. Intravenous in-

fusions and transfusions are given until the bleeding is stopped. No time is lost before the abdomen is opened, when an incomplete tear may be sutured under direct vision. The uterus is removed if rupture is complete or if it is in the lower uterine segment. Preferably hysterectomy is performed in all cases to prevent future rupture and to reduce sepsis. All cases are treated as if infected, with extensive drainage, unless the rupture has occurred in the upper segment spontaneously during pregnancy.

## CONCLUSIONS

1. Thirty cases of death from rupture of the uterus in New Jersey, 1937-1941, were studied. Apparently all cases are not diagnosed or reported.

2. The chief causes of rupture were multiparity, prolonged labor and dystocia, and trauma at delivery, version being most conspicuous.

3. Every use should be made of prophylaxis: prenatal care, meticulous examination, x-ray pelvimetry, consultation, smooth gentle delivery, prolonged labor questioned, and early resort to cervical Caesarian section.

4. When rupture occurs much valuable time is lost by delaying surgical treatment.

5. Hysterectomy is indicated in most cases of rupture.

144 South Harrison Street

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## A LESSON FROM A DEATH CERTIFICATE

### NUMBER FORTY-THREE

Patient refused at first to be delivered in a hospital but after being 15 hours in labor went to the hospital and after 14 hours additional was delivered by forceps by another physician. Gravida 1, para 0.

Patient immediately went into shock, and one hour later had a severe hemorrhage and died. Was patient exhausted by the long labor or was the cervix ruptured during delivery?

Details of history are too meagre to tell. She was given paraldehyde, morphine, and hyoscine during her labor. She may have been in a poor condition to stand a long labor and forceps delivery of an occiput posterior position.

More and more attention is now being given to improving the patient's general condition before labor starts.

A. W. BINGHAM, M.D.

# STATE ACTIVITIES

## INDUSTRIAL MEDICINE

### COMMITTEE ON INDUSTRIAL HEALTH

J. M. CARLISLE, M.D., Chairman

#### PHYSICAL EXAMINATIONS

Millions of our skilled industrial workers are being shifted to new jobs. Already working under conditions of increased stress and strain they are called upon to operate machines to which they are unaccustomed, to face new industrial hazards, including exposure to toxic dusts and fumes. Clearly, our all-out war effort cannot attain the peak of its efficiency unless an effective program for the prevention of accident and illness among industrial workers is instituted.

This enlarged program is intended to insure the detection and correction of health implications which might be overlooked in the production program. Industry, through its own health organizations, will redouble its efforts to provide and protect healthy workers, but the program is so large that every family physician remaining in civil practice should, through refresher courses, literature and active participation, prepare himself to contribute effectively in this worthy effort.

The industrial man-power of our country may be reduced either by accident or disease. To offset the hazards entailed by the use of untrained employees, unsafe procedures, and defective or improperly designed machinery or equipment it is essential that the physician in industry make every effort to maintain the health of the worker at the highest possible standard. One of the best means of achieving this objective is through a program of comprehensive and periodic physical examinations of the entire industrial personnel. Such a program should include:

1. Physical examination of every employee, new and old, in rotation beginning with the president of the company.
2. A routine reexamination of all employees every two years.
3. Special reexamination, including electrocardiograms, of all employees over the age of forty-five at least once a year.
4. Special reexamination every year of all workers engaged in hazardous occupations.
5. Periodic reexamination of all workers exposed to toxic substances, the type and fre-

quency of such examinations to be governed by the following criteria:

- a. Age of the employee.
- b. Physical condition of employee (as revealed by the periodic health examinations).
- c. The type, duration and severity of exposure.
- d. The degree of the worker's known reaction to the toxic environment.

Concurrent with the unparalleled increase in manufacturing activity incident to our war effort, an increase in tuberculosis among defense workers is to be expected. Not only must industry draw its man-power from the general population, of which a certain proportion is highly susceptible to tuberculosis, if not already in the early stages of the disease, but confinement and overcrowding of living quarters, on transportation lines and in work-shops, together with exposure to various dusts, and to contagion will tend to activate latent infections and to spread the disease among others.

In view of these considerations, steps have already been taken by the New Jersey Industrial Hygiene Service to combat the anticipated increase in tuberculosis. On July 1, 1942, this organization made available to industry a transportable fluorographic unit, including personnel. Working in coöperation with your Committee on Industrial Health and Hygiene and the New Jersey Tuberculosis League, this service will make 35 mm. films and will follow any of these which show suspicious or abnormal conditions by films of standard size for confirmation and diagnosis. All suspected cases of tuberculosis or potential tubercular conditions will then be reported to the State Department of Health through the local health agency, and the worker will be referred to his family physician for prophylaxis and treatment.

By means of the health examination program outlined above and the fluorographic service described, it is believed that the incidence of accidents and illness among workers in war industries can be reduced to a minimum.



## 1942 ANNUAL MEETING OF THE HOUSE OF DELEGATES

### EXECUTIVE OFFICER'S ABSTRACT

1. 1941 Minutes of the House of Delegates approved as forwarded.
2. Election:
  - President-Elect: Ralph K. Hollinshed (1 year)
  - First Vice-President: Joseph F. Londrigan (1 year)
  - Second Vice-President: Samuel Alexander (1 year)
  - Secretary: Alfred Stahl (1 year)
  - Treasurer: George J. Young (1 year)
  - Trustees (3 years):
    - James F. Norton (at large)
    - Thomas B. Lee (4th District)
    - Harry R. North (3rd District)
    - David W. Green (5th District)
  - Councilors (3 years):
    - Christopher C. Beling (1st District)
    - S. Emlen Stokes (4th District)
  - A. M. A. Delegates (2 years):
    - Wells P. Eagleton
    - Hilton S. Read
    - Thomas K. Lewis
  - A. M. A. Alternates (2 years):
    - Elmer P. Weigel
    - Lancelot Ely
    - Clarence W. Way
  - Delegate to Connecticut: C. Byron Blaisdell (1 year)
  - Alternate to Connecticut: William G. Herrman (1 year)
  - Finance and Budget: Herschel Pettit (6 years)
  - Publication: Henry C. Barkhorn (3 years)
3. Honorary Member—Dr. S. Josephine Baker, Belle Mead
4. 1943 Annual Meeting—Last week in May, 1943, Atlantic City
5. Budget—\$73,418.00—1942-43 fiscal year
6. Dues for 1943—\$17.00 per member
7. Resolutions adopted:
  - a. Remission of Dues:

That the Society go on record to pay the dues, either by remission or credit, of all members serving full time in the armed forces and so certified by the President and Secretary of their respective County Society, up to the time of the 1943 annual meeting.
  - b. Medical Service Administration

That the Medical Service Administration be retained as an active organization for the purpose of continuing operation of the Farm Security Plan and for the study and development of plans to provide medical care for the indigent.
  - c. Medical-Surgical Plan

That the Medical-Surgical Plan transact business for one year in those counties in which it has been or will be approved by the respective County Medical Societies.
  - d. Dr. Edward J. Ill

That the Secretary of the Society be instructed to transmit to Dr. Ill an expression of our satisfaction at hearing of his recovery and our confidence and expectation of having him with us next year.
8. Recommendations adopted:
  - a. Definition of Chiroprody

That the N. J. Delegates to the A. M. A. recommend to the Council on Hospitals and Medical Education the advisability of the Council's taking over the inspection of chiroprody schools with an attempt to establish a basic definition and define the scope and limitations of practice that can be made by this Council.
  - b. "This Is the House That Jack Built"

That this report, which is now being studied by a special committee of the Board of Trustees, be left with this special committee for continued study and report.
  - c. Eagleton Resolution re National Health Program

That the matter be referred to the Board of Trustees with power.
  - d. Radiological Society Resolution re Medical Service Administration

That the resolution be received and the information be referred to the proper committee. (M. S. A.)
9. Constitution and By-Laws—Amendments adopted:
  - a. By-Laws, Chapter VIII, Section 2, after "Committee on Finance" introduce "Committee on Scientific Work".
  - b. By-Laws, Chapter VIII, after Section 5, insert "Section 6—Committee on Scientific Work—The Committee on Scientific Work shall", etc. (see No. 20, Trans.).
  - c. By-Laws, Chapter VIII, renumber the remaining sections by adding one to each number.

## 10. Committee recommendations adopted:

## a. Medical Defense and Insurance

1. Renewal of the existing contract for Medical Defense through our official broker, Messrs. Faulhaber & Heard.
2. Renewal of the present contract on Accident and Health Insurance through Messrs. E. & W. Blankstein, our official broker.

## b. Welfare Committee

1. That some advisory committees be dispensed with until renewed evidence of need is again apparent.
2. Standards for Infant Resuscitation be published in *The Journal* and commended to the attention of the Society members and the hospital authorities.
3. Compensation for the Orthopaedic Surgeon in the care of indigent crippled children; that the men in this State now doing this work be classified into three groups, depending upon their experience, training and clinics they run, and that each member of each group be compensated on a flat yearly basis.
4. The institution of refresher courses to be operated at the close of the war, to further the training of medical officers discharged from the services.
5. Reduction of hospital out-patient load by 75 per cent—Committee on Hospital Relationships, Committee on Medical Preparedness with the Hospital Association to further study the matter and report to the House of Delegates, which is urged to appoint a committee to work jointly with the Hospital Association to prepare recommendations to be sent to the County Societies and to the individual hospitals.

(No report on "further study of matter" was made to House of Delegates and no "committee to work jointly with the Hospital Association" was appointed by the House of Delegates.)

6. During the coming year all officers of the Society be encouraged to submit their talks in advance to the Public Relations Committee; the Committee serving as a mechanism for distributing the talks through the proper channels to the public.
7. The Public Relations program be confined to assistance in the war effort.
8. The Press Association and New Jersey Clipping Bureau services be continued.
9. The library of scripts be expanded by contributions suitable for lay audiences made by physicians who have addressed these audiences on health subjects.

## c. President-Elect

1. A restudy during the coming year of the office of President-Elect and its abolition, returning to former custom of a regularly elected President and three Vice-Presidents.
11. No action taken on following through oversight:
- a. Amendment to Article VII of the Constitution (final vote).
  - b. Resolution re Commissions in the U. S. P. H. S. (Recommendation in Committee "A" report deferred till later. Report on this by Trustees referred to Resolutions and Memorials Committee at last session. No further consideration of resolution given by Reference Committee or House of Delegates.
12. Annual Registration  
Resolution for adoption and passage of legislation for annual registration lost.

## THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA

### 117TH ANNUAL COMMENCEMENT

The One Hundred Seventeenth Annual Commencement was held on June 5, 1942. The commencement address was delivered by Alfred P. Haake, A.B., M.A., Ph.D., Economist and Lecturer, on "Today's Challenge for Tomorrow".

The graduating class numbered 131, bringing the total number of graduates to 16,945.

The graduates represented twenty different states, the Territory of Hawaii and Puerto Rico. Eighty-five members of the graduating class were commissioned as First Lieutenants in the Medical Reserve Corps of the United States Army.

The honorary degree of Doctor of Science was conferred upon Harris Peyton Mosher,

A.B., M.D., Emeritus Professor of Laryngology and of Otolaryngology, Harvard Medical School.

The Annual Alumni Dinner was held on June 4, 1942, at the Bellevue-Stratford Hotel with 550 alumni in attendance. Dr. Warren B. Davis, '10, President of the Alumni Association, presided. The speakers were Mr. Robert P. Hooper, President of the Board of Trustees; Honorable Franklin Spencer Edmonds, representing the Board of Trustees; Lieutenant Colonel Frank P. Strome, Class of 1915 Medico-Chi, Professor of Military Science and Tactics at The Jefferson Medical College; Dr. William Harvey Perkins, Dean of The Jefferson Medical College, Class of 1917, representing the faculty; Dr. Paul Keller, Pennsylvania, representing the Class of 1917; Thomas F. Duhigg, Commander M.C., U.S.N., representing the Class of 1902, and Dr. Harry Copping Bantly, Pennsylvania, President of the graduating class and representing the Class of 1942.

Alumni Day and Ex-Internes' Day were held on June 3 and 4, in the Clinical Amphitheatre of the Jefferson Hospital.

The Graduating Class of 1942 presented a portrait of Dr. H. E. Radasch to the college on March 26, 1942.

The 38th General Hospital Unit of the Jefferson Hospital left for Camp Bowie, Texas, on May 15, 1942. Approximately sixty-two doctors and one hundred nurses composed this unit. Dr. Baldwin L. Keyes, Lt. Col., M.C., U.S.A., is the Unit Director.

On May 27, 1942, the Degree of Doctor of Science was conferred upon Dr. Randle C. Rosenberger, Professor of Preventive Medicine and Bacteriology at The Jefferson Medical College, by the Philadelphia College of Pharmacy and Science.

The following additions and promotions in the teaching corps have been made during the past session: Dr. William Harvey Perkins, Dean and Professor of Preventive Medicine; Dr. Hobart A. Reimann appointed Acting Head of the Department of Experimental Medicine; Dr. Baldwin L. Keyes, Professor of Psychiatry; Dr. Harold W. Jones, Professor of Clinical Medicine and Hematology and appointed to the Thomas Drake Martinez Cardeza Chair of Clinical Medicine and Hematology; Dr. Martin E. Rehfuess, Sutherland M. Prevost Lecturer in Therapeutics in the Department of Medicine; Dr. Clifford B. Lull, Clinical Professor of Obstetrics; Dr. Garfield G. Duncan, Clinical Professor of Medicine; Dr. William J. Harrison, Associate Professor of Ophthalmology; Dr. David R. Morgan, Associate Professor of Pathology; Dr. Robert A. Matthews, Associate Professor of Psychiatry; Dr. William H. Schmidt, Associate Professor of Physical Therapy; Dr. Charles Lintgen, Assistant Professor of Gynecology; Dr. Mario A. Castallo, Assistant Professor of Obstetrics; Dr. Arthur First, Assistant Professor of Obstetrics; Dr. Robert A. Groff, Assistant Professor of Neurosurgery; Dr. Reynold S. Grifith, Assistant Professor of Medicine.

### SUPPLEMENTARY LIST NO. 3

### MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Alford, Ralph, Montclair (7)  
Becker, George L., Paterson (16)  
Bender, Louis, Newark (7)  
Berg, Samuel, Newark (7)  
Black, Max S., Linden (20)  
Blaisdell, C. Byron, Long Branch (13)  
Brittain, Elmore G., Bound Brook (18)  
Calasibetta, Charles J., Newark (7)  
Calvert, William C., West Orange (7)  
Caprio, Orland G., Newark (7)  
Chapman, Walter I., Bayonne (16)  
Coburn, J. Wesley, East Orange (7)  
Collins, Louis K., Glassboro (8)  
Copleman, Hyman B., New Brunswick (12)  
Dodge, James T., Trenton (11)  
Eigen, Louis A., West Orange (7)  
Emory, George B., Morristown (14)  
Etheridge, Charles H., East Orange (7)

Evans, David P., East Orange (7)  
Fiering, A. M., Mountain View (16)  
Fischbein, Martin M., Irvington (7)  
Garrison, George H. H., Camden (4)  
Greenberg, Jacob L., Newark (7)  
Griswold, Merton L., Jr., Plainfield (20)  
Haldeman, Robert E., Mt. Holly (3)  
Hawke, Edward, Newton (19)  
Hawkes, Stuart Z., Newark (7)  
Heatley, William, Red Bank (13)  
Heller, George, Englewood (2)  
Higi, Joseph E., Orange (7)  
Kaplan, Henry L., Newark (7)  
Klein, Edward C., Jr., Newark (7)  
Kraemer, Manfred, Newark (7)  
Lakiszak, Roman T., Jersey City (9)  
Lance, Elton W., Rahway (20)  
Levendusky, D. E., Clifton (16)



Levy, David, Clifton (16)  
 Lipshutz, Charles, Bayonne (9)  
 Lipstein, William, Irvington (7)  
 Loeser, Lewis H., Newark (7)  
 Lyon, Archibald, North Arlington (7)  
 Mann, Benjamin, Perth Amboy (12)  
 Markel, Albert G., Paterson (16)  
 Miller, Nathan, Irvington (7)  
 Mohair, John P., Marlboro (13)  
 Molitch, Matthew, Atlantic City (1)  
 Moore, Dean C., East Orange (7)  
 Moore, James A., Montclair (7)  
 Nickman, E. Harrison, Atlantic City (1)  
 Nicoll, George L., Dover (14)  
 Normand, Alphonse F., Perth Amboy (12)  
 Nussbaum, Harvey E., Newark (7)  
 O'Brien, Edwin J., Plainfield (20)  
 Pavia, John R., East Orange (7)  
 Read, Hilton S., Ventnor (1)  
 Reich, Mortimer, Newark (7)

Resch, Henry U., Bloomfield (7)  
 Restaino, Charles F., Newark (7)  
 Robbins, Charles M., Newark (7)  
 Robertson, Euston S., Kearny (7)  
 Robie, Theodore R., East Orange (7)  
 Sadoff, Joseph, Elizabeth (20)  
 Schotland, Clement F., Newark (7)  
 Shor, David, East Orange (7)  
 Siegel, Jack G., Newark (7)  
 Silver, Harry B., Newark (7)  
 Snedecor, Spencer T., Hackensack (2)  
 Sonnenberg, Arthur, Newark (7)  
 Spencer, James H., Franklin (19)  
 Stamps, G. Ruffin, Pleasantville (1)  
 Teichholz, M. H., Passaic (16)  
 Vento, Sebastian J., Trenton (11)  
 Vincent, Nicholas F., East Orange (7)  
 Wildman, George A., Trenton (11)  
 Yankowitz, Michael F., Newark (7)  
 Zimmer, William, East Orange (7)  
 Zweibel, Leonard, Newark (7)

## PROCEDURE IN PROCUREMENT AND ASSIGNMENT

Some of our individual members seem confused as to the best procedure to follow in their own case. These physicians are advised to discuss their individual problems with Dr.

Schlichter or Dr. Scott. Telephone Mitchell 2-0675 or call in person at 31 Clinton Street, Newark.

## SUPPLEMENTARY LIST OF MEMBERS NO. 4

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### ACTIVE MEMBERS

Allen, Raymond N., 144 Harrison st., E. Orange (7)  
 Calasibetta, Chas. J., 37 Longfellow av., Newark (7)  
 Caprio, Orlando G., 517 Roseville av., Newark (7)  
 Carlucci, Angelo M., N. J. State Village, Skillman (7)  
 Cetrulo, Gerald I., 234 Mt. Prospect av., Newark (7)  
 Gluckman, I. Edward, 78 Johnson av., Newark (7)  
 Harrington, Walter L., 104 S. Munn av., E. Orange (7)  
 Higi, Joseph E., 529 Park av., Orange (7)  
 Levy, David, Fort Slocum, New York (16)  
 Lifland, Bernard D., 35 Shanley av., Newark (7)  
 Longo, James J., 64 Ridge rd., N. Arlington (7)  
 Longshore, Walter E., Jr., 216 Oakw'd av., Orange (7)  
 Mann, Benjamin, 527 Amboy av., Perth Amboy (12)

McCullough, Water A., Essex Co. Hosp., Cedar Gr. (7)  
 Muller, Joseph H., 867 S. 13th st., Newark (7)  
 O'Connor, Paul A., 157 Roseville av., Newark (7)  
 Rawitz, Sidney B., 42 Chancellor av., Newark (7)  
 Reinartz, Paul V., 190 Bellevue av., Bloomfield (7)  
 Russell, Leslie C., 192 Clinton av., Newark (7)  
 Shaw, Ned, 632 Belgrove drive, Kearny (7)  
 Sonnenberg, Arthur, 18 Custer pl., Newark (7)  
 Tilton, William R., 763 Broad st., Newark (7)  
 Whitken, Albert, 1056 North av., Elizabeth (20)

### ASSOCIATE MEMBERS

Marchigiano, Michael A., 441 N. 13th st., Newark (7)  
 Tibor, Alfred, 725 High st., Newark (7)

## IMPORTANT

### RESTRICTED COVERAGE IN MALPRACTICE ACTIONS

Your attention is again called to the statement on page 655 of the December, 1941, *Journal of The Medical Society of New Jersey*, printed over the name of Christopher C. Beling, M.D., Chairman of the Medical Defense and Insurance Committee.

Read also the A. M. A. Journal of September 13, 1941, page 936, which sets forth the

possible liability for damage suits under certain circumstances.

Please understand that this restricted coverage is not intended to protect an assured for civilian practice. If there is any possibility of such need, the contract should be continued for full coverage.

## AIMS AND ACTIVITIES OF THE STATE DEPARTMENT OF HEALTH

By J. LYNN MAHAFFEY, M.D.

Director, N. J. State Health Department, Trenton, N. J.

Delivered before The Medical Society of New Jersey at its Annual Meeting, May 21 1941

The spotlight is centered on the part The Medical Society of New Jersey is playing in the developing public health program of our State. This is as it should be. No public health program could possibly progress without the active support of the medical profession.

Public health is today an evolutionary process. But its rock-ribbed foundation is in the medical profession. The innovation of a former generation is the accepted practice of today. With the help of the medical practitioner, we have gone far. Progress has been made, diseases arrested, the life-span extended, and living made happier. Without the members of the medical profession any health program would of itself disintegrate and be futile. We want your cooperation to continue and be intensified.

### MEDICAL DEFENSE

Logically, our thoughts turn to the part the medical profession must play in the present national emergency.

Apace with the operations of the Selective Service System for military training, the State Defense Council is making preparations for the welfare of the civilian population. Your Medical Preparedness Committee of The Medical Society of New Jersey is ably represented by Dr. Charles H. Schlichter of Elizabeth, as chairman, and Dr. Norman M. Scott, as secretary. The members of this committee have worked diligently with the State Department of Health in the deliberations of the Governor's State Defense Council. Doctors will be called upon for professional services, under a plan having its sponsorship with the Medical Society and the State Department of Health.

The peace-time set-up of the State Department of Health can be readily converted to an emergency basis. In that organization, the medical profession, naturally, must be the dominant consideration. Unquestionably, with that in mind, the legislature has made the medical

profession, as such, the dominant group in the New Jersey State Department of Health.

### STRUCTURE OF HEALTH DEPARTMENT

Dr. Frederick P. Lee, of Paterson; Dr. Walter G. Alexander, of Orange, and Dr. Martin H. Collier, of Camden,<sup>1</sup> are the representatives of the medical profession on the New Jersey State Board of Health. Other professional societies have lesser representation, a dentist, veterinarian and engineer.

Into the public health profession in recent years has come an increasing number of physicians in our various bureaus. These men have been recommended by the Medical Society, subject to confirmation by the State Civil Service Commission. Likewise, our larger cities have selected medical practitioners as municipal health officers. I cite these instances to emphasize the close relationships between the medical and public health professions.

### DISTRICT HEALTH OFFICES

Our cities being organized on a well-ordered public health plan, it is the rural communities (and there are 567 separate health units in New Jersey) which need assistance and supervision most from the State agencies.

To overcome our shortcomings in the municipalities which do not have adequate health personnel, we have established at strategic points, district health officers, under supervision from our central offices in Trenton. These district health offices are at Mays Landing, Pitman, Freehold, Mt. Holly, Somerville, Hackensack and Dover; and recently we established a district health office for the Fort Dix area, at Cookstown, in Burlington County.

These district health offices provide a health service for a combination of rural areas which otherwise would lack such facilities.

The Department has adopted the sound and constructive development of State Health dis-

1. All are members of The Medical Society of New Jersey.

tricts with properly qualified medical and other technical personnel as one of its immediate objectives.

#### DISTRIBUTION OF FUNDS

New Jersey's citizens are comparatively large income-tax payers. A substantial proportion of federal funds are returned to the State Treasury here for public health purposes.

New Jersey sent to the federal government about 184 million dollars in all types of federal taxes in 1938. We received, through all kinds of federal assistance, some 84 million dollars that year, leaving us a "credit" of more than one hundred million dollars in Washington.

Increasingly, the U. S. Public Health Service and the Children's Bureau of the U. S. Department of Labor have shown a disposition to supply the state with funds to take care of health work not provided for by state, county or municipal treasuries.

Of course, with the acceptance of federal funds, the federal government's supervisory powers have extended over the expenditures of those moneys. The picture reveals a gigantic network extending from the nation's capital to the States' capital, then reaching out into those communities whose health officers have secured assistance to expand their programs under the federal-state-municipal set-up, where otherwise important preventive health work would lag.

From Washington have come regulations for a larger participation of the medical profession in the allocation of federal moneys. This is on the theory that the medical man, by education and training, is better qualified for specific professional duties than one without such training.

Four years ago the State Department of Health was spending about \$450,000 annually. This year we will spend almost \$1,100,000. We have in our employ, directly or indirectly, more than five hundred persons.

#### ROLE OF THE PRACTITIONER

We welcome the participation of the medical profession in our program.<sup>2</sup> We need the phy-

2. Attention is directed to the October, 1941, issue of *Public Health News* which graphically portrays many of the functions of the Health Department.

sicians of N. J.; and we believe that the practitioners need the facilities of the State Department of Health, professionally, individually, and as an organization.

You have been invaluable in our program for the distribution of biologicals—for the immunization of children against smallpox and diphtheria. The medical profession in N. J. has coöperated in every move we have made for the betterment of health of the people of N. J. New Jersey takes great pride in its record of *no case of smallpox for nearly a decade*, while in other parts of the nation the federal authorities report some 12,000 to 14,000 cases annually.

Community sanitation, in which your part is considerable, is reflected in the expenditure of millions of dollars for sewage and water purification plants by our cities. *No water-borne outbreak of typhoid fever has been traceable to a publicly-supervised water supply in fifteen years*. This is all the more remarkable when we recall the disruption of the Bridgeton water supply system by a cloudburst a few years ago. Emergency chlorination happily prevented any typhoid casualties.

Increased industrial demands in New Jersey for water supplies has emphasized the importance of inter-connection of city supplies to avert a shortage.

Industrial hygiene, so effective in Connecticut and a few other states, presses for a better plan in New Jersey. In this you will be of great help in assisting the Legislature to establish such a program for New Jersey so that illnesses apparently inherent in particular manufacturing processes may be studied and remedied.

The State Health Department has formally endorsed your proposal for the reporting of cancer, so that research may be made by governmental agencies and reporting systemized. Here, too, the medical profession will play the leading part, for without proper reporting of cancer very little progress may be made outside of the profession itself.

#### LABORATORY FACILITIES

You are all familiar with the excellent work the State Laboratory is doing. Passage of the



pre-marital examination law and the pre-natal statute have increased our work 300 per cent. Unfortunately the Legislature and the State House Commission have been unable to give New Jersey a suitable public health building and our employees do remarkably good work in crowded quarters and under most distressing conditions. We are far from disheartened in this respect, and hope that our continual appeals for adequate laboratory facilities in the interest of the medical profession and the general public will eventually find satisfactory response.

In the examination of specimens of communicable diseases and suspected cases of diseases our State Laboratory is doing an excellent humanitarian job. Here the medical practitioner who has occasion to call upon us for service realizes how much he is indebted to the State Department of Health for assisting him in the diagnosis of disease.

Finally, in the evolutionary processes of an expanding health department, we extend to your organization an invitation to coöperate with us, so that our health services may be improved, rendering satisfaction not only to the medical profession but to the general public.

New Jersey's was the first State Health Department bacteriologic laboratory established in the United States.

Previous to 1895 a number of the larger cities in the United States had established similar laboratories, and this State early recognized how essential this work was to public health.

The work of our bacteriologic laboratory has grown since its beginning, so that during last year 250,000 specimens were examined. These had been received from patients suffering from various diseases and from suspected carriers of communicable diseases from all sections of the State. These specimens are sent in by physicians from patients in their private practice, from draftees, National Guard, clinics, Home Guard, industrial plants engaged in defense work, C. C. Camps, and in compliance with the premarital and prenatal laws.

They are collected in mailing outfits, complying with the postal regulations for their transmission through the mails. These outfits are provided by the laboratory and are kept in

a large number of repositories throughout the State, usually in drug stores or offices of local boards of health, and are also sent direct to physicians. These outfits are supplied without cost, and no charge is made for examinations, so that the only expense which the sender has to meet is the very small sum required to transmit the specimen through the mails. Over 300,000 outfits were supplied last year.

The examination of a large number of specimens for evidence of syphilis accounts for the greatest increase. The enactment of the premarital and prenatal laws and the long-continued educational and control program have been responsible for the steady rise in the number of specimens submitted for examination.

The tremendous increase (almost 400 per cent) in the number of specimens examined yearly for evidence of syphilis for the past five years is amazing. It has been necessary to assign more personnel to take care of this work but the examinations are made in the same two small rooms and the space is now inadequate to handle this volume of work. In 1936, we had 54,000 specimens. In 1938, we examined 97,000. And by 1940, the annual number exceeded 200,000. Of the 201,418 specimens examined for evidence of syphilis, 65,527 specimens were received for premarital and prenatal examinations. These examinations and the number of positive reactions obtained are:

Premarital tests .....	39,304
Positive premarital tests .....	467
Prenatal tests .....	25,429
Positive prenatal tests .....	327

The complement fixation test is made on all specimens of blood and spinal fluid and the Kahn test is made on all specimens giving any degree of reaction. The Kahn test was made on 19,757 specimens.

The total number of examinations on specimens during the fiscal year made by the Bureau of Bacteriology was 251,068. In some instances these examinations constituted more than one test on the same specimen.

Our laboratory gives you physicians a 24-hour, seven-day-a-week service in emergencies.

The State House telephone exchange operators get in touch with our laboratory staff chief or his assistants if an emergency specimen must

be examined forthwith, and probably save a human life.

It is required by the premarital and prenatal laws, for the purpose of each of these acts, that a standard laboratory blood test shall be a test for syphilis approved by the Director of Health of New Jersey and shall be made at a laboratory approved by the Director to make such tests.

A number of laboratories in this State have been approved to make these tests on applicants for marriage in New Jersey. For some time, some laboratories outside this State have also been approved. The laboratory of the New York City Health Department was the first laboratory so approved and was furnished with New Jersey certificate forms for the convenience of persons residing in New York City and wishing to be married in New Jersey. Residents of New Jersey wishing to be married in New York City could have the blood test made in the laboratory of the New Jersey State Department of Health. The New York City certificate form would then be issued so that a license may be obtained to marry in New York City. Later the laboratories of the Pennsylvania State Department of Health and the Philadelphia City Department of Health Laboratory were approved, also the laboratories of the Army, Navy and Marine hospitals and the U. S. Public Health Service.

Recently all state laboratories have been approved for the examination of blood specimens and have been furnished with a supply of certificate forms for residents of each state who expect to be married in New Jersey.

Residents of New Jersey wishing to be married outside the State must have the blood test made in the laboratory of the New Jersey State Department of Health to be recognized by states that are willing to accept tests made in New Jersey. These states, however, will not accept tests made in any other laboratory in New Jersey, and the registrars of this State will not accept examinations made in other laboratories outside the State except those laboratories approved for these examinations by the Director of Health of this State.

The approval of all State Department of Health laboratories is most helpful to out-of-

state residents who wish to be married in New Jersey. Reciprocal approval of the N. J. State Laboratory will be helpful to New Jersey residents who expect to be married in other states.

#### VENEREAL DISEASE BUREAU

In our Bureau of Venereal Disease Control, we have a variety of services and materials available to physicians. These include: a consultant service on special medical problems; educational literature for waiting room tables; instructions for patients; services of fifteen trained case workers available to private physicians in following up delinquents, contacts and sources of infection. More general use of this service by physicians is invited.

We also provide graduate courses for physicians. For the fall course in 1940, 251 doctors registered. For the spring course of 1941, 133 were registered.

More complete reporting of cases of gonorrhea and syphilis under treatment by private physician is requested. Information about delinquents and contacts will help our department to be of greater service to public health. The policy of secrecy about persons who stay under treatment is never violated and physicians need have no fear of embarrassment because of reporting cases by name and address to the State Department of Health as the law requires.

#### STATISTICAL WORK

The prompt reporting by physicians of cases of reportable diseases coming to their attention forms the groundwork for a communicable disease control and epidemiologic structure, not only in the municipality where the case occurs but also far beyond such local area.

For instance, it is of real value to know in what sex, age group and color, tuberculosis is most prevalent and whether the incidence of cases increases or decreases over definite periods and in view of definite preventive measures.

Weekly, a summary of case reports of communicable diseases in each state is forwarded to Washington where New Jersey's rate of any communicable disease can be compared with other states and the country as a whole. Com-

ing outbreaks are frequently forecast by such comparisons long before they appear in a state.

Obviously, if cases of communicable diseases could be prevented from occurring, the machinery for investigation, restriction and follow-up would not have to function. Complete immunization of our people against a communicable disease, when such immunization is practical, would be the ideal control method. While such a situation might be considered Utopian, a very practical approach to this ideal is possible in smallpox and diphtheria. The State Legislature has made it possible for the State Health Department to make available free for the use of physicians, through stations at strategic points about the state, both smallpox vaccine and diphtheria toxoid. Good use is being made of these materials with effective results.

Certificates of death also have a definite public health value in addition to their very practical value for legal purposes. Tabulations and studies of causes of death given on such certificates are of great value in pointing out problems of public health significance even far beyond the problem of communicable disease.

May I point out, however, the correctness of forecast trends in death rates from various

causes based upon information in death certificates can be no more accurate than the information (including the true cause of death) set forth on such certificates. In this respect the physician's skill and accuracy in fixing and recording causes of death constitute the basis of many public health observations and much public health planning.

#### MATERNAL WELFARE

The recent Washington conference of State and Territorial Health Officers urged that there be no curtailment of our services in the promotion of maternal and child health.

In New Jersey we have a field physician for each county to acquaint physicians with our maternal and child health program.

Among his duties is the investigation of all puerperal deaths.

Physicians in New Jersey are free to call in consultant obstetricians in low-wage group families. The consultant's fee is paid from Social Security Funds. Physicians may also call nurses to assist in home deliveries of low-wage group families. The nurse's fee is also paid from Social Security Funds. During the past year, physicians called nurses to assist in 1,482 home deliveries.

406 Warwick Road, Haddonfield, N. J.

## OBITUARIES

### DR. ROY A. GREGORY

Dr. Roy Gregory died in Malden, Mass., on June 28, 1942, after a prolonged illness. Dr. Gregory was born on February 21, 1893, in Tupelo, Miss.; took his pre-medical course at the University of Mississippi, and received his medical degree from the University of Virginia in 1925. He served his internship at the University of Virginia Hospital and later at the Post-Graduate Hospital in New York City.

Dr. Gregory previously practiced in Plainfield and was a member of the Medical Staff and Senior Attending Surgeon in the Eye, Ear, Nose and Throat Department in Muhlenberg Hospital, where he had been connected since 1929. Last May he sold his home in Plainfield and moved to Malden, Mass.

He was a member of the Union County Medical Society, The Medical Society of New Jersey and the A. M. A. He was a consultant at the State Hos-

pital for Epileptics at Skillman and a member of the Twin Brook Country Club.

The interment took place in Malden.

### DR. FREDERICK A. WILD

Dr. Frederick A. Wild of Bound Brook died on July 14, 1942, in Muhlenberg Hospital, Plainfield, after practicing his profession for more than fifty years. Dr. Wild was born in Jersey City and graduated from New York University in 1892. He immediately settled in Bound Brook.

Dr. Wild was a member of The Medical Society of New Jersey and the Somerset County Medical Society. He was a member of St. Paul's Episcopal Church and the Masonic Fraternity.

The funeral was held at his home and he was buried in Jersey City.

The Somerset County Medical Society placed upon its minutes a resolution expressing their loss of a valued member, a good physician and a kindly friend.



## ● THE BULLETIN BOARD ●

### PHYSICAL THERAPY TECHNICIANS

Columbia University announces that beginning September, 1942, a program of professional studies for the training of physical therapy technicians will be offered. This training and instruction will extend over a two-year period and has been organized in compliance with the requirements set down for such programs by the Council on Medical Education and Hospitals of the American Medical Association. The course is being set up in University Extension in close relationship with the College of Physicians and Surgeons of Columbia University, the Nursing Education and Health and Physical Education Departments of Teachers College. The clinical and laboratory instruction will be given at the Vanderbilt Clinic, Neurological Institute, Presbyterian Hospital and New York Orthopedic Dispensary and Hospital.

Two years or 60 semester hours of college, including courses in physics and biology, shall be required, or graduation from an accredited school of nursing or an accredited school of physical education.

A Certificate of Proficiency in Physical Therapy will be granted by Columbia University to those completing the course. Further information may be obtained by writing the Office of the Committee on Physical Therapy, Room 303 B, School of Business, Columbia University, New York City.

• • •

### GRADUATES IN AVIATION MEDICINE

First Lieutenant Sam Lemkin of Newark and Captain William D. O'Gorman of Jersey City.

• • •

### DEPUTY CHIEF E. M. S.

Dr. Gerald W. Sinnott of Jersey City has been commissioned in the active reserve of the Public Health Service as a Deputy State Chief of Emergency Medical Service, to carry out the program developed by the Medical Division of the Office of Civilian Defense and the U. S. Public Health Service. The State Chief of Emergency Medical Service is, as formerly, Dr. Charles H. Schlichter of Elizabeth. These physicians also serve as responsible agents of the state and of the Medical Division of the Office of Civilian Defense and of the Public Health Service.

### MEDICAL CARE PLANS

Medical-Surgical Plan of New Jersey, providing payment for medical and surgical care rendered hospitalized patients, has been in operation for one month. Approximately 4000 persons have been enrolled or have been approved for enrollment. The reaction of the press, industry, employed groups and individuals has been favorable and encouraging. Progress reports of this Plan will appear periodically in this *Journal*.

The Farm Security Plan entered its second year of operation on May first. Experience during the first year warranted an increase in the fees payable physicians. The present fees are: office calls, \$1.50; house calls, \$2.50; obstetrical delivery and post-partum care, \$30.00. The present subscription rate will *not* support the payment for care rendered hospitalized cases. An increase in the subscription rate to cover care in hospital may become available if arrangements can be made to provide such care in hospital wards to private patients on a state-wide basis. The consensus of opinion expressed in the majority of counties justifies the statement that this Plan does improve the distribution of medical services among low-income farm families and does fill a need among these people.

*Medical Service Plans*, as an effort of organized medicine, are operating in thirteen States. They deserve the unreserved support of every physician. They are constructive, practical attempts to protect the private practice of medicine against the threats to its future welfare.

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Get behind them. If they fail—other organizations, not controlled by the profession, may soon supply the answer. If you have not signed your agreement with Medical-Surgical Plan, please do so. Further information regarding Plans operating in New Jersey or in other States may be obtained by addressing Medical Service Administration of New Jersey at 31 Clinton Street, Newark, N. J.

NORMAN M. SCOTT, M.D., Executive  
Vice-President and Medical Director.

## BOOKS RECEIVED FOR REVIEW

**MANUAL OF STANDARD PRACTICE OF PLASTIC AND MAXILLOFACIAL SURGERY.** Prepared and edited by the Subcommittee on Plastic and Maxillofacial Surgery of the Committee on Surgery of the Division of Medical Sciences, of the National Research Council, and Representatives of the Medical Department, U. S. Army. Pp. 432. Phila., W. B. Saunders. 1942. \$5.00.

**MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS.** By John Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. 3d ed. Pp. 1303. St. Louis, C. V. Mosby Co. 1942. \$12.50.

**TREATMENT IN GENERAL PRACTICE.** By Harry Beckman, M.D. 4th ed. Pp. 1015. Philadelphia, W. B. Saunders Co. 1942. \$10.00.

## BOOK REVIEWS

**The Essentials of Occupational Diseases.** By Jewett V. Reed, B.S., M.D., F.A.C.S., and A. K. Harcourt, B.S., M.D. Pp. 225. Springfield, Illinois, Charles C. Thomas. 1941. \$4.50.

The subject of occupational diseases, as seen through the eyes of these two authors over a period of thirty years, provides much useful information for the industrial physicians as well as laymen confronted with industrial disease problems. It is not exhaustive, as the field is much too large to be covered in 225 pages, and the worst criticism that can be made of it is that it does not touch the subject of how these diseases can be avoided by the worker or prevented by the employer. On other aspects of occupational disease, however, it is timely, has an excellent bibliography, and can be highly recommended.

**Comparative Biochemistry. Intermediate Metabolism of Fats. Carbohydrate Metabolism. Biochemistry of Choline.** Edited by Howard B. Lewis. Pp. 247. Lancaster, Pa., The Jaques Cattell Press. 1941. \$2.50.

Volume five of Biological Symposia continues a valuable series of publications on fundamental subjects and is itself devoted to the important topics of fats and carbohydrates and the biochemistry of choline. The section devoted to the latter should be read and thoroughly absorbed by every practitioner of medicine. Therein appear discussions of work which will be the foundation for many future discoveries.

The short section on comparative biochemistry discusses the end products of nitrogen metabolism in plants and in animals and the merging of growth factors and vitamins. The importance of the sections on fat and carbohydrate metabolism is self-evident.

As with the previous volumes, volume five is a credit to the publishers and should be in the library of every physician who wishes to keep abreast of the most recent developments.

C. ABBOTT BELING.

**Internal Medicine in Old Age.** By Albert Mueller-Deham, M.D., and S. Milton Rabson, M.D. Pp. 396. Baltimore, Williams and Wilkins Co. 1942. \$5.00.

An excellent review for any internist and of value to the general practitioner in treating those of advanced age. A good bibliography is at the end of

each chapter. The need for illustrations is not great and their lack does not detract from an easily flowing construction.

The single criticism is that the authors do not adequately support occasional statements of fact with corroborative evidence.

E. P. CARDWELL.

**Medical State and National Board Summary.** By William H. Krupper, M.D., with a foreword to the candidate by Earl S. Hallinger, M.D., Secretary of the New Jersey State Board of Medical Examiners. Pp. 369. Paterson, N. J., The Colt Press. 1942. \$4.50.

Published in our own state, this treatise, with a foreword by the Secretary of the State Board of Medical Examiners of New Jersey, seeks to reduce anatomy to a diagram and succeeds to an amazing degree. Such method of treatment will undoubtedly interest many and should be most helpful to the "cramming" student. Other subjects receive a similar treatment in the form of outlines.

Although entitled a summary, it is quite inclusive, covering 370 pages.

E. P. CARDWELL.

**Eye Manifestations of Internal Diseases.** By I. S. Tasman, M.D. Pp. 542. St. Louis, C. V. Mosby Co. 1942. \$9.50.

Dr. Tasman's book was written "in an effort to bridge any existing gap between the eye manifestations and the other medical aspects of the internal diseases". It is essentially a listing of practically all known eye manifestations of general disease or of disease in another organ of the body, preceded by several chapters on anatomy, examination of the eyes, and description of ocular lesions.

The organization of the material is occasionally confusing,—for example, the chapter on structural abnormalities and manifestations includes glaucoma, and that on the examination of the iris includes the lens, vitreous, eye-grounds and orbit.

Because of the great number of subjects mentioned, but few could be discussed.

There are many illustrations. Some of these, especially the photographs of eye-grounds, have little or no value, but most are helpful. It is indeed refreshing to find a book with so many up-to-date photographs of patients, and with none taken from text-books of fifty years ago.

A. RUSSELL SHERMAN.

**The Surgical Practice of the Lahey Clinic, Boston, Massachusetts.** Pp. 897. Philadelphia, W. B. Saunders Co. 1941. \$10.00.

There are certain books which make available a portion of surgical knowledge in an attractive form. The Surgical Practice of the Lahey Clinic should be included among them.

In this volume we have a collection of papers which have appeared recently in various medical journals. The articles have been grouped under eleven main headings. The shortest sections of the book are those which deal with the breast, biliary tract, pelvis, kidney and prostate gland. The surgery of the gastro-intestinal tract is discussed in two sections. The first section contains those articles pertaining to the stomach, duodenum and small intestines; the second, those pertaining to the colon, sigmoid and rectum. Together, they constitute roughly one-third of the book. The section on the thyroid and the section on anesthesia particularly should be mentioned. There are 376 illustrations, all carefully chosen to tell their story within a minimum amount of space.

In his preface, Dr. Lahey states that the book represents a true cross-section of the Lahey Clinic work as practiced today; its methods, techniques, diagnostic measures and results. It is a product of the actual experience of clinic members having a large amount of material, and it reflects the diversified interests which characterize the group of men working in a clinic such as this.

T. CAMPBELL HOOTON.

**Synopsis of Ano-rectal Diseases.** By Louis J. Hirschman, M.D., F.A.C.S. 2d ed. Pp. 315. St. Louis, C. V. Mosby Co. 1942. \$4.50.

This little book of ano-rectal diseases is an excellent compendium for ready reference for the general practitioner. Because the author's vast experience suggests the exclusion of a great deal of unnecessary detail, only the essential facts appear.

A thorough study of the first three or four chapters will give the practitioner an excellent outline for office proctology, and should provide the incentive for greater interest in this branch of medicine than has been shown in the past. We trust it will stimulate the use of frequent digital proctological examination; a much neglected diagnostic procedure.

Many suggestions for therapy will be found incorporated in the text. Except for the simplest surgical procedures enumerated, the reviewer's opinion is that wider experience is necessary for the more intricate operations described. Much of value will be the reward for patient reading of this excellent volume.

J. GERENDASY.

**Pathology of the Oral Cavity.** By Lester Richard Cahn, D.D.S. Pp. 240. Baltimore, William Wood, The Williams & Wilkins Co. 1941. \$5.50.

In the opinion of the reviewer, this excellent little manual on the neglected subject of oral pathology fills a definite need in the library of the practicing dental surgeon. The author has obviously made a real effort to eliminate from his text consideration

of those very rare diseases of the oral cavity which are, in the last analysis, almost exclusively of academic interest. In this way he has been able to condense the entire subject into less than 250 pages.

The style of the writing is good. The words flow effortlessly and indicate an excellent command of the subject. Polysyllabic profundity is conspicuous by its absence. To readers of a subject which so readily lends itself to the dry didactic approach, this refreshing style is a pleasure.

The author is to be highly commended for pointing out that numerous benign oral lesions, such as the diffuse hyperostoses, may resemble, on section, malignant tumors like the osteogenetic sarcomas. It has been observed that the general pathologist when confronted with such lesions, due to his general lack of familiarity with oral pathology, is prone to label them malignant. Most pathologists before reaching a final decision in these cases will consult with other men in their community. While this method will certainly reduce the margin of error, it should not be forgotten that an expert oral pathologist in any but the largest communities is a "rara avis" indeed. From this point of view, Dr. Cahn's book might well be studied by the pathology staffs of most hospitals.

One final criticism on the question of brevity. While conciseness is fine, it must not be carried to an extreme. The entire discussion on osteomyelitis of the mandible is covered in five pages, including illustrations. Such treatment is bound to be superficial.

In summation Dr. Cahn has written a fine manual on an interesting subject and is to be congratulated on a splendid contribution to dental science.

A. A. ACKERMAN.

**Urology in War, wounds and other emergencies of the genito-urinary organs, surgical and medical.** By Charles Y. Bidgood, Lt. Comdr. (M.C.), U. S. N. R. Pp. 78. Baltimore, Williams & Wilkins Co. 1942. \$5.00.

For the general practitioner who may be confronted with a urological emergency and unable to get specialized help, this little manual is exactly "what the doctor ordered". The illustrations by Didusch are outstanding and aid in giving a clear picture of the situation with which the reader may not be entirely familiar. The format is such that the work can be packed into very little space and the text is so concise that it eliminates wading through a mass of comparatively unessential detail at a time of emergency.

The chapter on neurogenic bladders deserves particular mention because of the way it clarifies the handling of these very distressing cases. The chapter on anesthesia, while possibly somewhat extended for a general emergency manual, is extremely clear. In fact, to catalogue all the good points of this work would be to list its table of contents.

It is heartily recommended to every one who may encounter a urological emergency while away from expert help, and it may even be recommended to the urologist as a handy, quick reference in traumatic urology.

W. L. JAMES.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

August, 1942

No. 8

RETURN of the arrested case of tuberculosis to his safe and full economic efficiency is the final objective of treatment. This aspect of the care of the tuberculous, however, has received far too little thoughtful study. Fifty per cent of patients discharged from sanatoria still die of tuberculosis within five years. This social waste must be stopped. Dr. Aitken calls attention to the need of a more scientific approach to the problem.

### WORK TOLERANCE FOLLOWING TUBERCULOSIS

The original purpose of a sanatorium was largely the segregation of a patient with an infectious disease dangerous to his neighbors. Enough bacillary cases were cured or arrested through rest, fresh air, proper food, to encourage the development of sanatoria for the "early case" which held good hope of cure. Refined methods of diagnosis soon showed that the minimal case was a rarity and that prolonged bed rest was nearly always essential. This principle is still valid even with the introduction of collapse therapy as an effective form of treatment. The criticism arose that we were making healthy loafers out of sick workers and it was too often justified.

Thereupon, occupational therapy crept in to relieve the tedium of enforced idleness and then followed a more constructive approach known by the awkward name of rehabilitation which included education and vocational training. Treating the disease while the patient is an invalid in the hospital is no longer considered sufficient. Adequate care involves preparation for maximum social and economic adjustment when the disease is arrested or apparently cured.

This duty devolves upon the sanatorium. "As soon as an estimate of the disease processes is arrived at and the course of treatment decided upon, a beginning can be made in education. An early analysis of the patient's educational and occupational background, of his interests and aptitudes can be made and a course of training outlined. This can be made to synchronize with his medical treatment and other activities permitted, and it can be carried throughout the full length of stay of the patient in the sanatorium. As well, there

are many of the facilities of the sanatorium which can be used for both training and physical rehabilitation. All the program requires is the coordination and coöperation of the various staffs of the hospital and occupational therapists who are willing to accept adult education as being a branch of occupational therapy.

"The appraisal of the ability of the individual to do some line of work begins with securing past-work history and continues throughout the period of training. Also the counseling of the patient and testing for special aptitudes by trained observers aids in appraising. It not only helps evaluation but it gives direction to effort, eliminating much time wasted by trial and error methods, and is most useful in creating interest and coöperation in patients."

Appraising the physical stamina of the patient to stand the strain of normal life is difficult. We have no clinical or mechanical tests to use as reliable measures of work tolerance. We cannot say just how many foot pounds of muscular energy this individual can safely expend, nor how much mental strain he can endure without reactivating his disease. Furthermore, our knowledge of just how much energy a given job requires is but vaguely known. Job analyses are usually made on the basis of speed rather than foot pounds of energy required.

Our present recourse, then, is the study of the patient as an individual during his stay in the sanatorium. Close observation will give us an appraisal of his inherent resistance to breakdown from physical efforts, nervous upsets, or even intercurrent infection. With the knowledge thus

gained the trial method of graduated exercise should be undertaken with careful watching. "Signs and symptoms of intoxication indicate over-exertion and need for return to rest therapy. Rise in temperature, increase in pulse rate, fatigue and loss of weight, sputum changes in quantity and content, changes in sedimentation rate and blood count and later increase in pathology as shown by X-ray, suggest reactivation.

"In order to establish with more surety that a patient can withstand sustained efforts, a period of physical rehabilitation should be followed before discharge of the patient. Before it can be certain that the patient can lead a normal life and stand up to ordinary work conditions, sanatorium routine and cure hours should be broken. One of the hardest things for a patient is to discontinue the mid-day rest period. If he can be put on a full work schedule of forty hours a week for a few months before discharge and is able to play after work without undue fatigue, he should be able to do the same outside. This can be readily done in a sanatorium where there is a constant need for help and often to the advantage of the sanatorium."

In addition to the graduated exercise, test inferences may be drawn from X-ray studies of the characteristics of the disease during treatment, such as a tendency toward fibrosis, rapidity of healing and such evidences of good resistance. On the other hand, very extensive disease with reduced vital capacity, distortion of chest structures and possible cardiac embarrassment are obvious causes of low work tolerance.

In connection with its rehabilitation program, for over ten years Niagara Sanatorium (New York) has given close study to the problem of determining work tolerance. While only about half the patients are considered to afford hope of effective vocational rehabilitation, careful study is made of every case since whatever occupational therapy is possible is employed routinely. Patients have been given aptitude and personality tests by

personnel from the National Tuberculosis Association and the State Rehabilitation Department has made provision for the completion of courses in a number of cases.

Only modest claims are made for the results thus far achieved. "It is true that the death rate in the sanatorium has remained unchanged, but the readmission rate has decreased, as have deaths of patients after discharge. This decrease in readmissions counterbalances the increased initial length of stay. Of fifteen patients who have been aided by state rehabilitation, only one has since broken down and this was the result of lobar pneumonia in a patient with a complete thoracoplasty. As well as the evident individual results we have obtained, the morale of the entire population has improved. Few patients leave now because of boredom. Also, it has given us an employment agency, not only for temporary help but for permanent employees who have been tried and their ability proved. Some of our most valuable employees are ex-patients, trained in the peculiarities of our set-up and most valuable in that they carry with them the patients' viewpoint and an understanding of patients' trials and tribulations.

"To summarize, a rehabilitation program can be developed in a small sanatorium with benefit to patients individually and collectively and with advantages to the sanatorium. Tolerance for selective work can be built up in patients, but the evaluation like that for determining disease status, being dependent upon personal judgment of the significance of the individual's reactions, is only approximate. The program can be carried on at no great cost to the community and over a period of time the community, as a whole, will be repaid many times over."

*The Need for Developing Work Tolerance Following Pulmonary Tuberculosis, A. M. Aitken, M.D. Paper given at annual meeting of National Tuberculosis Assn., Phila., Penna., May 6-9, 1942.*

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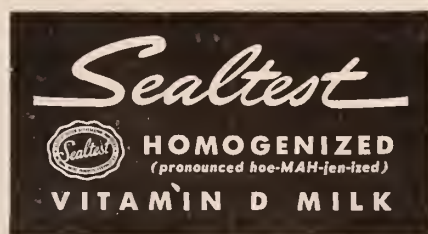
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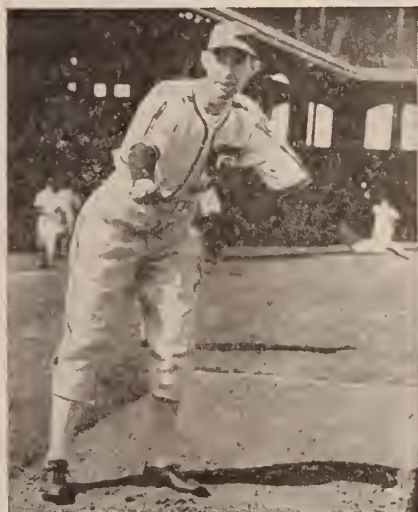




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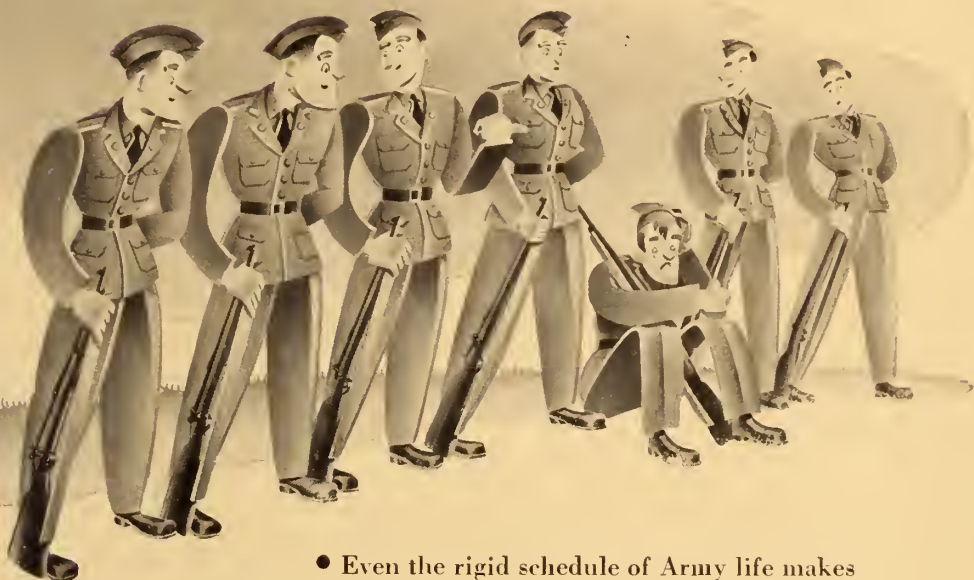


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*of*

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**THE OFFICIAL TRANSACTIONS**

Haddon Hall, Atlantic City, New Jersey

*April 21, 22 and 23, 1942*

*Issued as a Supplement to*  
*The Journal of The Medical Society of New Jersey, August, 1942*

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## Table of Contents

	Page
MINUTES OF THE HOUSE OF DELEGATES	
1. First Session, Tuesday . . . . .	5
2. Second Session, Wednesday . . . . .	19
3. Third Session, Thursday . . . . .	20
WOMAN'S AUXILIARY MINUTES	
1. Pre-Convention Meeting . . . . .	36
2. Fifteenth Annual Meeting . . . . .	36
3. President's Annual Report . . . . .	38
4. Post-Convention Board Meeting . . . . .	39
5. Treasurer's Report . . . . .	40
6. Attendance . . . . .	40

## INDEX

	Page		Page
Administrative Program for 1942-43 (President-Elect Marsh) .....	16	Legislative Committee Report .....	9, 34
Annual Meeting of 1943, Place and Date .....	34	Marsh (President-Elect) Proposals .....	15
Annual Registration .....	7, 11, 18, 25, 26, 27, 32	Medical Defense and Insurance Committee Report .....	10, 25
Atlantic County Medical Society Resolution .....	18, 26	Medical Examiners, State Board of .....	11, 25
Speakers on		Medical Preparedness Committee .....	5, 7, 23
Barbash, Samuel .....	11, 31	Medical Service Administration .....	5, 6, 14, 23, 26
Barkhorn, Henry C. ....	28	—Majority Report .....	23
Bien, Frank A. ....	28	—Minority Report .....	23
Cosgrove, Samuel A. ....	30	Medical-Surgical Plan .....	5, 14, 23, 26
Hallinger, Earl S. ....	27	Nominating Committee Report .....	19
Kraker, David A. ....	29	Post-Graduate Education Committee Report ..	25
Lewis, Thomas K. ....	28	President—	
Norton, James F. ....	30	Announcements .....	5
Schaaf, Royal A. ....	31	Annual Report .....	5, 20
Shipp, Hammell P. ....	27	Streamlining the Convention .....	5
Snedecor, Spencer T. ....	30	President-Elect Marsh—	
Tansey, William A. ....	29	Administrative Program for 1942-1943 .....	16
Ulmer, Chester L. ....	29	Proposals .....	15
Wegrocki, Adolph .....	26	Report .....	20
Approval of 1941 Minutes .....	5	Public Relations Work in Executive Offices ..	14, 20
Assessment (see "Dues")		Publication Committee Report .....	21
Baker, Dr. Josephine .....	15, 34	Radiological Society Resolution .....	26
Budget Appropriations for 1942-1943 .....	8, 14	Reference Committees	
By-Laws, Proposed Amendments .....	15, 32	"A" .....	20
Chiropody, Definition and Scope .....	35	"B" .....	21
Credentials Committee .....	5, 25	"C" .....	22
Dues—		"D" .....	24
For 1943 .....	14, 22	Constitution and By-Laws .....	32
Remission of .....	14, 22	Miscellaneous Business .....	34
Eagleton Resolution .....	18, 25	Resolutions and Memorials .....	25
Editor's Leave of Absence .....	14, 20	Reporters' Duties .....	16, 32
Elections .....	19	Resolutions .....	18
Executive Officer—		Scientific Work Committee .....	15, 32
Acting Editor .....	14, 20	Secretary's Annual Report .....	7, 21
Report of .....	21	Treasurer's Annual Report .....	7, 22
Fall Clinical Conference .....	14, 20	Trustees, Board of .....	20, 24
Finance and Budget Committee Report .....	8, 22	—Supplementary Report .....	14, 20
Gillespie, Colonel Frank S., B.M.C. ....	5	United States Public Health Service	
Honorary Membership Committee .....	15, 34	Proposal .....	6, 14, 24
"House That Jack Built" (Burritt) ....	18, 24, 34	Welfare Committee Report .....	24
Ill, Edward J., Recovery Resolution .....	35	—Advisory Committees combined .....	24
Judicial Council Report .....	21	Woman's Auxiliary Advisory Committee Report	34



## PART ONE THE MINUTES OF THE HOUSE OF DELEGATES

First Session, Tuesday Morning, April 21, 1942

The first session of the House of Delegates, held during the One Hundred Seventy-sixth Annual Meeting of The Medical Society of New Jersey, convened in the Garden Room of Haddon Hall, Atlantic City, New Jersey, at 11:15 a. m. Dr. Thomas K. Lewis, of Camden, President of the Society, presided.

PRESIDENT LEWIS: Since there are members from more than four counties, and more than twenty Delegates present, I declare this One Hundred Seventy-sixth Annual Meeting of the House of Delegates officially in session.

The names of the Delegates and those serving on the eight Reference Committees are to be found in the printed program, a copy of which each delegate has.

I will ask the Chairman of the Committee on Credentials to render a report at this moment.

DR. ELIAS J. MARSH: There is no reason why the House should not proceed.

### APPROVAL OF MINUTES

PRESIDENT LEWIS: The minutes of the meeting of 1941 have been forwarded to the delegates under the title of "Official Transactions". What is your pleasure with regard to the minutes of the last meeting?

DR. CHESTER I. ULMER: I move that they be approved as printed.

The motion was regularly seconded, was put to a vote, and *was carried*.

### ANNOUNCEMENTS

PRESIDENT LEWIS: Before proceeding with the regular business, I have several announcements to make.

This year we have endeavored to streamline the meeting as an experiment, eliminating all of the official welcoming addresses formerly given. We would recommend that no discussions take place at this session. We would further urge that anyone with new business or new resolutions see to it that such matters are introduced under the heading of New Business at this session, in order that such person may appear for discussion before the meetings of the several Reference Committees.

I want to announce that Colonel Gillespie of the British Medical Corps will be present to enter in the discussions at the meetings held this afternoon and tomorrow afternoon. I make this announcement because his acceptance was not secured until after the program had been printed.

President-Elect Marsh took the chair.

CHAIRMAN MARSH: The next order of

business is the presentation of the Annual Report by the President. I have the pleasure of presenting him.

### ANNUAL REPORT OF THE PRESIDENT

Last May, when the administrative year began, the United States had committed itself to the task of converting this continent as swiftly as possible into an arsenal for the democracies of the world, engaged in a struggle for survival. In view of that fact, and because of the increasing likelihood of the eventual entry of this nation into the world-wide conflagration, it was our studied determination to repress such ambitions as we might have entertained for the initiation of any new projects. The wisdom of this decision was amply justified by the tragedy of December 7th.

Early in the year a meeting was held in Trenton, to which had been called all sub-committee and advisory committee chairmen. At this meeting each committee was requested to prepare itself for participation in the program of medical preparedness, to whatever extent its particular field of operation might impinge upon the various problems arising out of the approaching emergency. All these committees were urged to give full support to Dr. Schlichter and his Committee on Medical Preparedness in the task that lay ahead. How successfully this plan has worked out may be judged, without any belittling of Dr. Schlichter's efforts, by the fact that New Jersey, insofar as medical preparedness is concerned, holds an enviable position, at or near the top, in the list of States.

Our philosophy, with regard to the relationship of your President to the forty-odd committees, has been that each committee knew its job, had been functioning, in most cases, for a number of years and might better be permitted to operate with a minimum of interference. In line with this policy and in order to conserve energy and for purposes of economy, there has been no effort to score mileage or to build up a record of meetings attended. Rather, it was our consistent effort to keep away from meetings, except where attendance had been specifically requested or seemed advisable. In view of the fact that medical economics has been our particular hobby for many years, we derive considerable satisfaction from the fact that this year has witnessed the consummation of plans for the actual operation of the Medical Service Administration. That agency is now ready to place on sale policies for a Medical-Surgical Service. This agency has administered successfully the sickness benefit plan for the Farm Security Administration, and, in addition, has advanced far in negotiations with at least two

counties for taking over the administration of medical care of the indigent.

The Medical Profession is now faced with two clear-cut obligations, to which must be made subservient every individual or group consideration. The *first* of these is to help win this war. Nazism, Fascism and Jap-ery must be completely and permanently eliminated from the commonwealth of nations—for the sake of our children, for the sake of our children's children and for the future of the entire human race. About this there can be no equivocation. Whatever sacrifice this high resolve demands of us, as individuals or as an organized profession, matters not. Many of our hereditary rights and tenaciously held prerogatives may well be relinquished "for the duration", provided their relinquishment is essential to successful prosecution of the war against the gangster nations. Apparently, many of us do not yet fully realize the gravity of the situation. Selfishness and personal interests and preferences still occupy first place in our minds. That agreement of the A. M. A. with the Medical Corps of the Army and Navy must not be taken, and it never was intended to be taken, as a guarantee that each physician should be given the choice as to whether or not to serve or, if it should be his lot to serve with the armed forces, that he have his personal choice of jobs. The real, un concealed, purpose of that agreement was to make certain that the reservoir of medical ability of this country should be utilized to the best interests of the national need; and, that each physician should be assigned to that duty in which his endowed physique, his age, his experience and his peculiar training and ability might best serve his nation in its hour of need. To accomplish our determined objective, every doctor will be needed, either on the home front, in industry, in Public Health or with the armed forces of the United States. The doctor must not consider himself a privileged character. While attorneys, engineers and business men are being called from their professions to serve as privates in the ranks of the armed forces, the physician can have no democratic reason for claiming exemption. His peculiar qualifications and the need for his specialized skill in the defense of his country assure him officer rating, and for that fact he should be profoundly grateful. Already, the attitude of some of us has created an unfavorable impression with draft boards and with the public. The procurement and assignment division, which to a large extent places war-time control of the destiny of the individual physician in the hands of his profession, must be made to work. The efficiency and willingness with which organized medicine meets the present demands upon it, in this extreme emergency, will have much to do with the entire future of the practice of medicine in America.

The *second* objective of organized medicine must be the preservation of the American Way of the practice of medicine, insofar as is compatible with the demands of the emergency. Many new types of practice will be necessitated in the difficult days ahead. The distortion of normal industry, the emigration of labor and the production of new classes of indigency will cause new situations requiring

the provision of that much-alluded-to commodity, "adequate medical care". Wartime hysteria must not be permitted to "panic" us into precipitous abandonment of sound principles of medical economics but, rather, sane and considered judgment must be used in coping with each situation as it arises. Medical care in emergencies should be provided, insofar as possible, through the mechanism of our own existing agencies. This aim may be accomplished by the medical profession through cooperation with government in much the same democratic way in which we are at present coordinating our efforts with those of the Medical Corps of the Army and Navy.

One views with considerable concern the proposal, emanating from the United States Public Health Department, which aims to give commissions in the United States Public Health Service to many of the stay-at-home physicians. This is advocated, particularly, for members of hospital staffs. The reason for this proposal is based upon the proposition that, by virtue of holding such commissions, physicians serving in refugee camps and during disasters might be paid for their services. Cupidity and the idea of a uniform might well be potent factors in swaying many physicians to favor such a proposal. This matter should be weighed carefully by the House of Delegates, and its decision should be given the widest publicity in order that the profession of the State may present a united front. As a matter of fact, the whole scheme of civilian defense, supported by Federal and State legislation, places responsibility for all emergencies squarely upon the local community. Medical service is a very definite part of this scheme. When the doctor's community is struck by disaster, I suspect that the physician can "take it" along with the rest of his fellow townsmen and, if we have judged his character correctly, his primary urge will be that of service to the people of his community. He will gladly eat out of the common pot and share the discomforts and privations of his fellow citizens. When physicians are needed by industrial workers or for specific public health service, we have a procurement and assignment division in both county and State which can be trusted to fulfill the requirements of the situation. When new types of service are necessitated, we have, created by statute and now functioning, the Medical Service Administration which is legally empowered to administer and work out the details of any type of non-military medical service for government or any other responsible agency. In view of these facts we can see no reason for widespread enlistment of physicians in the United States Public Health Service.

At this Annual Meeting you will be called upon to take action upon a number of matters that will have far-reaching effects upon the future of the practice of medicine. The most important of these are as follows:

1. The proposal of the United States Public Health Department as outlined above.
2. The Medical Service Administration and its various ramifications. Your support of this agency and its ultimate success or failure will have much

to do in shaping the future of American Medicine. The conservatism and caution of the committee that has created this agency in every step along the way should be a sufficient guarantee of its solicitude for the welfare of the doctor. We hope to see that committee warmly commended and its efforts loyally supported.

3. The degree to which you support the work of the Medical Preparedness Committee, and, particularly, the Procurement and Assignment Division, will determine to what extent organized medicine is able to steer its own course during a national emergency to the best interests of the doctor and in meeting the common needs.

4. Annual Registration has long been frowned upon by the profession of this State. In the present emergency, its temporary adoption, at least, seems to offer the only hope for maintaining the State Board of Medical Examiners in its present position of independence from political control. Should that Board be forced to appeal to the legislature for appropriations with which to continue operation, all hope of retaining dedicated funds separate from politics will have been abandoned.

One of the great trials of your officers, in past years, has been the perfunctory consideration given to important issues and the hasty, and often inadequate action taken by the House of Delegates at its last meeting on Thursday morning. In this final session you will determine, direct and limit the action of the officers you will have elected to carry on your work for one of the most crucial years in the history of your Society. As a final call upon that loyal support which you have given during our year as President, it is our earnest plea that you make full use of the Reference Committees and that you stick it out to the bitter end at the final meeting of the House of Delegates—and see to it that your officers and your committees for the coming year shall be left in no doubt as to the will of the profession of New Jersey on the many vital matters which will be presented for your consideration.

CHAIRMAN MARSH: This report of the President will be referred to Reference Committee "A".

Action: Page 20.

President Lewis resumed the chair.

PRESIDENT LEWIS: Thank you, Dr. Marsh. I will ask the Secretary whether he has a report to submit at this time.

#### ANNUAL REPORT OF THE SECRETARY

Your Secretary desires to report that he has conscientiously discharged the duties of his office, as prescribed in the Constitution and By-Laws of The Medical Society of New Jersey.

Among the many meetings that he attended was the Annual Meeting of Secretaries and Editors held under the auspices of the American Medical Association in Chicago in November, 1941. This meeting was almost entirely given over to medical defense and medical service plans. This meeting was

fully reported in the December issue of the *State Society Journal* (page 658).

Members of the State Society who carry professional liability contracts will, in the event of their induction into military or naval service, be protected against claims for alleged mal-practice while engaged in such service to the same extent as they would be in private practice, and in cases where they leave an assistant in charge of their practice their contingent liability will be protected at half the regular premium. This reduction would, however, not apply where the doctor personally undertakes any portion of his civilian practice.

Policies terminated by reason of their holder's induction will be cancelled on a pro-rata basis, but we would caution the doctor not to return policies for cancellation until their last patient has been discharged, in order to be protected under the two-year statutory limit.

On March 15, 1942, the Society had 3,948 active members and 109 associate members. This is an increase of 180 active members over last year.

Fifty members died during the year; five were transferred from other states to our Society, and four of our Society transferred to other State Societies. There were eight transfers *within* the State, new and reinstated members totaled 201, and delinquent members numbered 241.

PRESIDENT LEWIS: This report of your Secretary will be submitted to Reference Committee "A".

Action: Page 21.

Has the Treasurer a report to make?

#### ANNUAL REPORT OF THE TREASURER

##### STATEMENT OF RECEIPTS AND DISBURSEMENTS

##### GENERAL FUNDS

June 1, 1941, to March 31, 1942

##### RECEIPTS

Cash Balance, June 1, 1941 .....\$ 60,225.54  
Assessments

Atlantic .....	\$ 2,128.00
Bergen .....	4,512.00
Burlington .....	992.00
Camden .....	2,832.00
Cape May .....	416.00
Cumberland .....	976.00
Essex .....	16,636.00
Gloucester .....	768.00
Hudson .....	7,312.00
Hunterdon .....	480.00
Mercer .....	3,952.00
Middlesex .....	2,483.00
Monmouth .....	2,176.00
Morris .....	1,900.00
Ocean .....	480.00
Passaic .....	5,728.00
Salem .....	496.00



Somerset	1,056.00
Sussex	400.00
Union	5,376.00
Warren	560.00
	<hr/> 61,659.00
Revenue Not Anticipated	49.04
Publication, The <i>Journal</i> (net)	11,628.05
Commercial Exhibits (net)	5,058.33
Interest	172.50
Sale of Maternal Record Book to Hospitals	55.71
	<hr/> \$138,848.17

## DISBURSEMENTS

*Administration*

A- 1 Executive Salaries	\$ 5,833.33
A- 2 Executive Staff Salaries	4,945.00
A- 3 Executive Office Expense	953.10
A- 4 Executive Travel	811.26
A- 5 Rent—State Headquarters	2,430.90
A- 6 Treasurer	69.42
A- 7 Finance and Budget	19.31
A- 8 Bonding	
A- 9 Audit	308.46
A-10 Secretary	502.37
A-11 Unemployment Compensation	419.50
A-12 Insurance	302.24
	<hr/> \$16,594.80

*Journal*

B-1 Journal Publication	\$10,830.02
B-2 Cuts	170.40
B-3 Editor's Salary	1,976.00
B-4 Journal Office Salaries	1,290.00
B-5 Journal Office Expenses	401.90
B-6 Journal Travel	53.57
B-7 Medical History	
	<hr/> 14,721.89

*Welfare Committee*

C-2 Welfare Committee	\$ 326.94
C-3 Legislative Committee	2,948.51
C-4 Public Health Committee	1,027.78
C-5 Public Relations Committee	872.05
C-6 Medical Practice Committee	410.91
	<hr/> 5,586.19

*Special Activities*

D- 1 President	\$ 421.67
D- 2 A. M. A. Delegates	153.00
D- 3 Dues to Conferences	25.00
D- 6 Fall Clinical Conference	830.26
D- 8 Woman's Auxiliary	454.68
D-11 Medical Service Administration	7,334.78
D-12 Medical Preparedness Committee	1,132.04
D-13 Post-Graduate Education	.24
	<hr/> 10,351.67
E—Contingent	1,601.05
F—Legal	135.82

*Annual Meeting*

G-1 Annual Meeting Committee	\$ 136.07
G-2 Scientific Sessions	48.20
G-4 Woman's Auxiliary	51.63
G-5 Scientific Exhibits	100.18
	<hr/> 336.08
II—Pension	1,250.00
	<hr/> \$ 50,577.59

Accounts Payable—year ended May 31, 1941	\$ 726.40
Remission of dues to members in armed forces (net)	1,096.00
Advance to Medical Service Administration	2,000.00
	<hr/> 3,822.40
	<hr/> \$ 54,399.99
Cash Balance, March 31st, 1942	84,448.18
	<hr/> \$138,848.17

## PERMANENT CAPITAL FUND

	May 13, 1941	Mar. 31, 1942
4M U. S. Treasury Bonds	\$ 4,045.94	\$ 4,045.94
Investors Mortgage & Realty	1,836.25	1,665.25
Trenton Mortgage Service Co.	1,212.77	1,212.77
First National Bank of Paterson savings account	349.54	
Cash on Hand	120.75	641.29
7 \$1000 and 1 \$500 Government Defense Bonds	7,500.00	7,500.00
	<hr/> \$15,065.25	<hr/> \$15,065.25

## KIPP MEMORIAL FUND

## EYE, EAR AND THROAT SECTION

	May 13, 1941	Mar. 31, 1942
Howard Savings Institution	\$37.10	\$37.10

PRESIDENT LEWIS: This report will go to Reference Committee "B".

Action: Page 22.

The Finance and Budget Committee, Dr. North.

## ANNUAL REPORT OF THE FINANCE AND BUDGET COMMITTEE

## BUDGET APPROPRIATIONS FOR 1942-1943

A- 1 Executive Salaries	\$ 7,000.00
A- 2 Executive Salaries and Wages	5,980.00
A- 3 Executive Office Expenses	1,200.00
A- 4 Executive Travel	1,200.00
A- 5 Rent—State Headquarters	2,925.00
A- 6 Treasurer	150.00
A- 7 Finance and Budget Committee	50.00
A- 8 Bonding	82.00
A- 9 Audit	310.00
A-10 Secretary	1,500.00
A-11 Unemployment Compensation Tax	550.00
A-12 Insurance	350.00

B- 1	Publication of Journal	14,000.00
B- 2	Cuts	250.00
B- 3	Editor's Salary	1,200.00
B- 4	Journal Salaries and Wages	1,560.00
B- 5	Journal Office Expenses	500.00
B- 6	Journal Travel	100.00
C- 2	Welfare Committee	750.00
C- 3	Legislative Committee	3,800.00
C- 4	Public Health Committee	1,200.00
C- 5	Public Relations Committee	750.00
C- 6	Medical Practice Committee	600.00
D- 1	President	1,500.00
D- 2	A. M. A. Delegates (Atlantic City Meeting)	100.00
D- 3	Dues—Professional Conference and Allied Conference	50.00
D- 8	Woman's Auxiliary (ad-interim account)	510.00
D-11*	Medical Service Administration	14,000.00
D-12	Medical Preparedness and Procurement and Assignment	2,000.00
D-13	Post-Graduate Education Committee	100.00
E—	Contingent Fund	3,000.00
F—	Legal	1,000.00
G- 1	Annual Meeting Committee	1,200.00
G- 2	Scientific Program Committee	250.00
G- 4	Auxiliary Entertainment and Art and Hobby Exhibit	700.00
G- 5	Scientific Exhibit Committee	1,500.00
H—	Pension—Dr. Morrison	1,500.00
Total Budget		\$73,418.00

\*Including \$5,000.00 for Medical-Surgical Plan.

DR. NORTH: You will note that your Finance and Budget Committee have adopted a budget this year amounting to \$73,418. They have fixed the per capita tax or assessment at \$17. Both have the approval of the Board of Trustees, given at two different meetings, and in view of the fact that you are streamlining this meeting, I think it is unnecessary to read this long report. If you wish it read, I shall be very happy to do it. If there are any questions you would like to ask, I shall attempt to answer them; otherwise it is submitted for your approval.

PRESIDENT LEWIS: Thank you, Dr. North. I presume it includes remission of dues for men in the service for the coming year. This report will be referred to Reference Committee "B".

Action: Page 22.

## SUPPLEMENTARY REPORTS

PRESIDENT LEWIS: Now we will entertain only *supplementary* reports of officers and committees.

The Subcommittee on Legislation, Dr. Polak!

## SUPPLEMENTARY REPORT OF THE SUBCOMMITTEE ON LEGISLATION

Of the forty-odd bills having public health interest introduced at this session of the Legislature, the following is a report of the present status of several which are of especial interest to the Society.

*Senate Bill No. 10*—which amends the dental practice act, to make clear that physicians have the right to treat diseases of the mouth and to perform operations in oral surgery, passed both houses unanimously and was signed by the Governor on April 7th.

*Senate Bill No. 55*—which deletes from the Workmen's Compensation Act the arbitrary maximum of \$150 for medical and hospital care of hernia, passed unanimously in the Senate March 9th. We expect it to be moved in the Assembly next week.

*Senate Bill No. 68*—which would completely revise the Workmen's Compensation Act, was printed but has not yet been formally introduced. This bill has been considered by the Committee on Workmen's Compensation and its medical features particularly have been carefully studied. The Committee opposes the bill in its present form.

*Senate Bill No. 70*—which would add an optometrist to the State Board of Health, is in the Public Health Committee of the Senate, where we believe it will remain.

*Senate Bill No. 138*—which requires payment into the State Treasury of funds collected by professional examining boards, is in the Judiciary Committee of that body. If the bill is reported out, and we doubt that it will be, it is possible it may pass in the Senate.

*Senate Bill No. 217*—which was prepared by the Department of Health and the Society's Committee on Cancer Control, is in the Public Health Committee of the Senate. Because of the lateness of the introduction of this bill and that it carries an appropriation of \$25,000, it is extremely doubtful of passage.

*Assembly Bill No. 9*—which is identical with A-4, introduced at the 1941 session by Dr. Browne, and would repeal the Uniform Medical Practice Act, is in the Committee on Public Health where we feel quite certain it will remain.

*Assembly Bill No. 157*—sponsored by the optometrists, which would prevent opticians from replacing or duplicating lenses without another prescription, was assigned to the Committee on Miscellaneous Business March 30th. This Committee is referred to as the morgue, and any bill which is assigned to this Committee is dead for this session of the Legislature.

*Assembly Bills No. 170 and No. 171*—dealing with the sterilization of persons deemed unfit for parenthood, have been referred to the Miscellaneous Business Committee.

*Assembly Bill No. 189*—which provides for free distribution of typhoid vaccine and other biologicals to combat communicable diseases during epidemics caused by enemy action or other catastrophies,

passed the Assembly April 7th, and is now in the Public Health Committee of the Senate.

*Assembly Bill No. 229*—For the past twenty years, off and on, attempts have been made to draft a satisfactory definition of chiropody. We are able to report with considerable satisfaction that such a definition has been composed, and was offered as an Assembly amendment to Assembly Bill No. 229, which was sponsored by the chiropodists. The bill with the amended definition, which was agreed to by the chiropodists and this Committee, passed the Assembly unanimously April 13th. The definition, as to scope and limitations of practice, incorporates in the main the features of the definition that was proposed in the Chiropody Bill, Assembly 257, sponsored last year by our Society. We think the measure will pass in the Senate unless the Legislature decides to adjourn sooner than is anticipated.

There is one by-effect of the passage of Assembly Bill No. 229, containing a definition of chiropody, previously referred to, which we think is important enough to warrant brief comment: The efforts put forth year after year by the Society to combat legislation which would permit individuals or groups educationally unqualified to practice medicine, raises in the minds of some of the legislators at times a question as to whether the medical profession is not too arbitrary and monopolistic. The fact that in this bill (A.-229) a definition of chiropody, a minor branch of medicine practiced by a group outside of the profession, has been evolved by agreement between the chiropodists and this Society, will do much, we believe, to dispel this idea, and should have a good effect in our future legislative efforts.

*Assembly Bill No. 238*—sponsored by the Board of Medical Examiners, requiring annual registration of physicians, was introduced April 7th and referred to the Public Health Committee. The Committee on Legislation awaits a directive from this House of Delegates to advise the Legislature as to the Society's attitude toward this measure.

Very early in the session a bill which would have conferred the status of R.N. on graduate nurses who are not registered, was given to one of the Senators for introduction. The State Nurses' Association and the Board of Nurses' Examiners asked the assistance of this Legislative Committee in their endeavors to block introduction of the bill. Several conferences were held. We believe that the activities of this Committee were, in largest measure, responsible for the decision not to introduce the measure.

The only pending Federal legislation which we were asked by the Bureau of Legal Medicine and Legislation of the American Medical Association to attempt to influence was H.R. 1052, sponsored by Representative Tolan, of California, which will permit chiropractors to treat beneficiaries of the United States Employees' Compensation Act.

We were advised February 20th that a subcommittee of the House Committee on the Judiciary had recommended to the full Committee this bill, with an immaterial amendment, be favorably reported. Congressman Albert L. Vreeland of Essex, a member of the Judiciary Committee, but not of

the subcommittee which recommended a favorable report, in response to communications from the Society's Legislative Committee, and the Secretary of the Essex County Society, urging opposition to this measure, advised us that he would voice our objections to the Committee on the Judiciary. Congressman Vreeland, as a member of this committee, opposed a similar bill last year.

There has been no change in the status of this bill (H.R. 1052). It is still pending in the House Committee on the Judiciary.

PRESIDENT LEWIS: This report will go to the Reference Committee on Miscellaneous Business.

Action: Page 34.

#### SUPPLEMENTARY REPORT OF THE COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

DR. CHRISTOPHER C. BELING: Mr. President and Members of the Society: Just a brief supplementary report regarding the State Society's special Accident and Health Policy, effective May 1, 1942. We are putting into effect a reduction of rates from 10 to 33 per cent at various ages, as an extension of coverage, thus making our Physicians' Special Liability Policy issued by the National Casualty Company more advantageous than ever before. There is nothing to touch it in the East, and this is due to the favorable experience that the company has had.

Now, under the Physicians' Special Policy, insurance coverage will be extended for all disabilities except those due to an enemy act, such as bombing or shelling. Those desirous of cancelling their policies on entering the armed services may do that on a full pro rata basis.

#### NATIONAL CASUALTY COMPANY

Jersey City, N. J.

April 15th, 1942.

Dr. Christopher C. Beling  
111 Clinton Avenue  
Newark, New Jersey

Re: Reduction in rate—  
Physicians Special Policy

Dear Dr. Beling:

We are very pleased to advise you that we propose extending the coverage as well as reducing the rates for all ages on our Physicians Special Policy of the Medical Society, effective as of May 1st, for both new applicants as well as renewals coming due after that date.

The changes are as follows:

1. Extension of the limit of accident coverage to five years (60 months).
2. Elimination of our previous exclusion of disability due to "any venereal disease not innocently acquired in the actual practice of medicine".



3. Increase in the dismemberment benefit provision from the present principal sum of \$5000.00 in all policies regardless of monthly benefit, to a minimum dismemberment benefit of \$5000.00 in policies for \$100.00 per month, \$7500.00 in policies of \$150.00 per month, \$10,000.00 in policies of \$200.00 and \$300.00 monthly.

4. The inclusion of an accidental death benefit of \$1000.00 in all policies without any additional premium. (At present there is no accidental death benefit in the base coverage of the policy, requiring an additional premium for this coverage if desired.)

5. Although our Claim Department has always recognized that Pyogenic infections resulting from a cut or injury as an accident disability, we will include by special endorsement the following provision so as to stop misstatements by competitors as to our method of handling such a disability:

"Disability causing loss of time, death or dismemberment, due to Pyogenic infection, which shall occur with and through an accidental cut or injury shall be considered as accident and shall be paid under the respective provisions of said contract applying thereto."

6. Although the following premiums are quoted on an annual basis, we will henceforth accept quarterly and semi-annual premiums pro-rata, without additional loading for such installment payments.

Monthly Benefit	Accidental Death Benefit	Dismem- berment	Annual Premium Ages		
			to 50	51 to 60	61 to 65
\$100.00	\$1000.00	\$ 5,000.00	\$29.50	\$34.00	\$ 43.00
150.00	1000.00	7,500.00	43.60	50.35	63.85
200.00	1000.00	10,000.00	57.70	66.70	84.70
300.00	1000.00	10,000.00	84.90	98.40	125.40

Each rate above includes \$1000.00 accidental death benefit. Additional accidental death benefit ages up to 65—\$1.30 per \$1000.00 may be had for total limit of \$5000.00.

So that you can appreciate this reduction in rate (in addition to the other reduction in rate that was made effective as of January 1st, 1942), please refer to the rates shown on the colored pamphlet enclosed, which are the present rates, and compare them with these new rates shown on the white printer's proof sheet enclosed. To put it mildly, Dr. Beling, this rate reduction and extension in coverage will cause loss of sleep to all of our accident and health competitors throughout the State.

Sincerely yours,

E. AND W. BLANKSTEEN,  
(S) WILLIAM BLANKSTEEN.

These rate reductions, together with the reductions made January 1, 1942, average from 10 per cent to 33⅓ per cent at various ages.

PRESIDENT LEWIS: This report will be referred to Reference Committee "D".

Action: Page 25.

Has the State Board of Medical Examiners a report to present?

## STATE BOARD OF MEDICAL EXAMINERS

DR. SAMUEL BARBASH: As I understand it, this is not so much a report as it is an attempt to present the case for annual registration.

About a year ago Raymond Gram Swing, the noted news commentator, got "all boiled up" over the fact that while commenting on the most exciting news in history he had to stop in the middle of it while the announcer extolled the virtues of the cigar put out by the sponsor of the program. He felt that there was a definite loss of the sense of values—that while the cigar announcement was important to his sponsor yet it was trivial and insignificant in comparison with his news comment. As a result, the "middle of the program" announcement was deferred to the end.

I feel somewhat as Mr. Swing did. While Annual Registration is without doubt important to us in this State, we are giving entirely too much time, thought and worry to its discussion. Important though it is, it is trivial compared with other matters with which we have to deal, especially in these trying times when the entire world is being rocked by war and the lives and liberty of a greater portion of the entire human race are at stake. But since it is necessary to do so, I will present my plea for Annual Registration as briefly as possible.

During the course of the last few months, the Board of Medical Examiners appealed first to the Welfare Committee, then to the Board of Trustees, for their sanction of the introduction of legislation which would put into effect Annual Registration. In this we were unsuccessful, as both of these bodies felt the matter should be handled by the House of Delegates. Our reasons for wanting Annual Registration were enumerated, and I will repeat them in order to refresh your memories:

1. As a protection to the public from unlicensed practitioners, whether they are graduates of medicine, or not.

2. The Board of Medical Examiners has no way of knowing how many physicians are practicing in the State, even though we do have a record of all those who have been licensed. Many of these men have moved away or died.

3. While it is a legal requirement for each and every licensed physician to register with his local County Clerk, we do not know that this is always done. We have no record of the death of a physician unless he is a member of his County and State Society. This gives an unlicensed man an opportunity to take over a deceased physician's name. We have a case of this kind under investigation at the present time.

4. We have in our midst a large number of refugee physicians. Many of them were unable to secure licenses in New Jersey to practice their profession. However, some are licensed to practice in New York, and reside in New Jersey. This gives them an opportunity to practice in New Jersey without first having secured a license to do so. They are unable to obtain licenses because they cannot meet the requirements for citizenship. We

have no way of checking these individuals. I also refer to physicians from neighboring states who set up offices in New Jersey for certain months of the year; who send their families to the seashore for the summer, commute themselves and practice while "on vacation".

5. Physio-therapists are required to practice their profession under the direct supervision of a licensed physician. Some are working under unlicensed physicians.

6. In some states, pharmacists are not permitted to fill prescriptions written by physicians not licensed in those states. It would help New Jersey licensed physicians if this could be put into effect here.

7. There are many physicians who do not belong to county societies. They could be investigated and, if qualified, might be brought into the fold. We have no way of doing this at the present.

8. Twenty states already have Annual Registration. In New Jersey, Annual Registration is required of dentists, pharmacists, chiropodists and nurses. There are 4,000 druggists in New Jersey who pay \$2.00, and 1,900 drug stores that pay \$5.00 each. The Board of Pharmacy tells me they would be unable to function unless they had these funds to enforce the law.

Optometrists pay \$5.00, chiropodists pay \$3.00, even the nurse, with her limited income, pays \$1.00. All of these moneys are put into excellent use and without them, the various Boards would be unable to enforce the laws enacted for their benefit. Physicians should be added to this list.

9. Annual Registration is a vital necessity *financially* to the Board of Medical Examiners, as we are unable, without money obtained from this source, to properly carry out our duty and prosecute those violating the Medical Practice Act. The question may arise in your minds—Why is it that for many years the Board of Medical Examiners was able to finance its activities, and now they cannot? The answer is that at times in the past the Board had a large number of applicants for examination and reciprocity. At the present time, this has dwindled to a mere trickle. This has happened before, and at one time the Board members put their own note in the bank to get money to pay their help. You should not expect them to do this.

Our reasons for wanting permission to introduce the Bill for Annual Registration before the State Society met, were, first, the urgent need of funds without which we could not function; second, we wanted to perform efficiently the job for which we were appointed; third, we had been told the present session of legislature was to be a short one and it was imperative that the Bill be presented for action, so that it could become law this year. After being turned down by the Welfare Committee and the Board of Trustees, the Bill was introduced by Assemblyman Leon Leonard of Atlantic County, and is being held in abeyance pending action by the State Society.

Having given you our reasons for support of Annual Registration, it is no more than fair that I outline to you the arguments which were advanced *against* it; for these I will turn to the April issue of the Essex County Bulletin:

I quote:

"1. The withdrawal of the right to practice during any unregistered year. We are now legal practitioners for life, unless our license is revoked or suspended for legally defined reasons. With Annual Registration we would be legal practitioners only from one registration date to the next. There is a 90-day period of grace in the proposed law, but should one of us, for instance, be discharged from the Army on the 90th day and do an operation on the 91st day without renewing our registration, we would be very vulnerable in a malpractice suit should an alert lawyer say before a jury, 'Doctor, were you a legal practitioner in New Jersey when you performed this operation?'"

This objection can be easily overcome. The State Board can keep a physician registered while in the armed forces—without fee for the duration of his service, and exact no registration fee until the registration period following his return to private practice. If his return should occur immediately before the next registration period, he could still remain registered and remit his fee at a later date—ample time, probably three months, being given him to remit. As you all know, preference has always been given to war veterans in previous years by practically every state in the Union, and I can give you my assurance that our Board will not be found wanting in this manner.

"2. A right once surrendered is rarely restored."

No Right Is Surrendered. The only inconvenience is the payment of a small fee to protect the benefits *obtained by that right*.

"3. The annoyance of registering."

This is so trifling that it can hardly be used as an objection.

"4. The cost of registration."

This, to my mind, is the real reason for objecting to Annual Registration. If the Board can get the income from Annual Registration, this income will be used to protect *your* income. You will get in return many times the money paid by barring illegal practitioners and diverting their income into your pockets.

"5. The possibility of the imposition of a fine for not registering."

If there were no fine attached, registration could not be enforced. Besides, it would be unfair for 99 men to register and the 100th not register and get off scot-free.

"6. The fact that many county lists are complete and others could be made so by the mere hiring of a clerk to check on them."

In the first place, very few county lists are complete. Secondly, hiring a clerk by the Medical Board to check on lists puts an additional cost on the business of enforcing the Medical Practice Act. We don't have enough money now for our present work. How can we hire another clerk without funds to pay her?

"7. If the new State Constitution is enacted there will probably be no more segregated funds; however, the doctors will still be burdened with Annual Registration, our fees going into the State Treasury."

If this comes true, we would all be in the same boat. Besides, the Board would then have to get



its funds from the State Treasurer and the money collected, or at least a greater part of it, would still be used to enforce the Medical Practice Act.

One member has been quoted as saying "he was against Annual Registration because infractions of the law are tried in the civil, instead of the criminal courts." Personally, I think it would be foolish to have these cases tried in criminal courts, because in these courts cases take a long time, sometimes several years, before they come to trial by the local prosecutor's office; whereas with the present set-up they are tried by the Attorney General, which gives much quicker action without much interference or delay.

Someone else has said that the books of the Board of Medical Examiners are closed to others. This is untrue. Our books are open to anyone who wants to see them. There is an annual report made to the State Society. You have but to read it in your *Journal* when it is published.

The above, and probably other, reasons have arisen in the minds of many of the members and I think it would be well at this time to review the history of the State Board in order that we get a clearer picture of the entire matter. Years ago the medical profession of New Jersey, realizing that the public was not protected against an inferior quality of medical service and that encroachment on the income of its members was being made by others, appealed to the legislature for protection of the public and the physicians in the State, not only from physicians from other states who came here to practice, but from other so-called branches of the healing art, many of them pure frauds and cultists. This legislation was forthcoming and the Board of Medical Examiners was appointed, whose duty it was to enforce the law passed by the legislature.

Unlike the various committees of the State Society who are doing their best to advance the interests of the profession, this Board is looked upon as something outside the State Society. There was considerable lack of coöperation between these two bodies and, at times, considerable friction. Of recent years, with the dying off of some members of the old Board and the injection of fresh blood into the Board, there has been considerably more coöperation between these two bodies in the interest of the State Society, except in the present issue, when all efforts on the part of the Board to get favorable support for legislation asked for has thus far been unsuccessful. We have met with opposition at every turn. The State Society does not seem to realize that we were appointed to protect *their* interests, or if they do realize it, they seem to feel that it is our duty to enforce the law without their assistance and that it is up to us to do our own financing. At the same time, we have been prevented from financing it in the only way which would still keep us an independent Board, free from political pressure. You must realize that if we appeal to, and get funds from, the legislature we will be subjected to considerable pressure to close our eyes to infractions of the law by some favored political henchman or his friend. Goodness knows we meet with enough of it as it is and I

am sure we will meet with more under the conditions already mentioned.

To go back to the reasons advanced against Annual Registration, I think the real objection is the registration fee. It is a well-known fact that when the medical profession is called upon to donate its services, the value of which runs into hundreds and sometimes thousands of dollars annually, it is cheerfully given. This has been proven time and time again, *yet* when these same physicians are called upon to lay out a few dollars in cash, they immediately balk.

At the present time there are a number of hospital insurance plans sold to the public for three cents a day per person. Anyone may purchase hospital insurance to protect his pocketbook against serious inroads in time of illness. Many medical men approve and endorse these plans for the laymen, yet they object strenuously to putting up *less than one cent per day* to protect their own incomes and that of their dependents. Until now this was not necessary, as the Board of Medical Examiners was able to carry on without their financial assistance. Today we cannot do this. Is it unreasonable to ask the doctors themselves to put up the money to protect their own incomes? I doubt if the State Legislature will give us money to carry on. Because of lack of funds the Board bids fair to becoming a mere figurehead, instead of a law-enforcing body. I am positive that if a Bill were introduced to compel Annual Registration without cost to the physician, there would be practically no opposition.

It is also true that while obstruction after obstruction has been put in our way, there has not been one single constructive thought advanced by the objectors in the State Society to help us attain our end, which is their protection. Let us assume that you do not see eye to eye with the Board of Medical Examiners and refuse to sanction the Annual Registration Bill. What then? Do you want to enforce the Medical Practice Act? If not, there is no more to be said. If you do, how can this be accomplished? The answer is to see that the Board of Medical Examiners gets the funds to prosecute its work. How can these funds be obtained? Will the State Society itself advance the funds? Obviously not. Shall we apply to the legislature for funds? They may refuse, but should they accede to our request there may be unpleasant consequences. What other solution have you?

Will you wait until, forced by our lack of funds, illegal practitioners and cultists have infiltrated into your camp Japanese fashion before you start to drive them out? It will be much easier to keep them out than to drive them out. Must we always have Generals *Too-Little* and *Too-Late* with us? Must we always be on the defensive? Must we wait for a medical Pearl Harbor before we start to fight?

The Legislative Committee of the State Society is your Board of Strategy. The Board of Medical Examiners constitutes your shock troops. Give us the guns and ammunition and we will fight your battles.

In conclusion, I would like every one present to



keep in mind the fact that nearly all members of the Board are members of the State Society; that we also will have to abide by the law and register, and pay the fee; that we have nothing to gain personally. Lastly, I ask you to remember that we are trying to act for your best interests and you can make this possible by supporting Annual Registration.

PRESIDENT LEWIS: Thank you, Dr. Barbash. This report will be referred to Reference Committee "D" for their information.

Dr. Barbash, in order to get this matter before the House of Delegates, have you prepared a resolution?

DR. BARBASH: There is a resolution coming from the Atlantic County Medical Society, which will be presented when resolutions are called for.

PRESIDENT LEWIS: Very good, sir!

I will now call for a report of the Board of Trustees.

DR. COSTELLO:

#### SUPPLEMENTARY REPORT OF THE BOARD OF TRUSTEES

Since the submission of the preliminary report, your Board of Trustees has had two meetings—one on March 22nd and one on April 20th.

At the March 22nd meeting, the following recommendations of the Finance and Budget Committee were approved:

1. To omit the Fall Clinical Conference for the duration of the war.

2. To return the details of the work of the Public Relations Committee to the Executive Offices, under the supervision of the Public Relations Committee Chairman.

3. In accordance with the request of Dr. Henry A. Davidson, Editor, that he be granted a leave of absence without pay until the expiration of his present contract, and the work of the *Journal* Editor be assigned to the Executive Officer for the balance of the fiscal year at an honorarium of \$100.00 per month.

It was ordered by the Board that the responsibility for all exhibits be placed in the hands of the Executive Officer to eliminate duplication and to further reduce costs.

The Trustees approved the formation of the Medical-Surgical Plan by the Medical Service Administration and its policy to collaborate with the Hospital Plan of New Jersey in the sale of its contracts.

The question of annual registration was discussed and it was decided to refer this matter to the House of Delegates for action.

At the meeting on April 20th, the following actions were taken:

1. That the Medical Service Administration be retained as an active organization for the purpose of continuing operation of the Farm Security Plan or any other medical services for governmental agencies and for the study and development of

plans to provide medical care for the indigent and low-wage groups.

2. That the Medical-Surgical Plan of New Jersey transact business for one year in those counties in which it is approved by the respective County Societies.

These two recommendations are referred to the House of Delegates for consideration and approval.

The following recommendations of the Finance and Budget Committee were approved and are referred to the House of Delegates for consideration and approval:

1. That the Society go on record to pay the dues, either by remission or credit, of all members serving full time in the armed forces of the United States, and so certified by the President and Secretary of their County Societies, up to the time of the 1943 Annual Meeting.

2. The adoption of the budget for the year 1942-1943, \$73,418.00 total.

3. The assessment for 1943 be \$17.00 per member.

The following recommendation, presented by the Committee on Medical Preparedness, was referred to a committee of three members of the Board for study in conjunction with Dr. Schlichter and report to the House of Delegates on Thursday morning:

*Whereas*, In March, 1942, the Surgeon General of the United States Public Health Service and the Chief Medical Officer of the Office of Civilian Defense published a joint agreement recommending the granting of commissions in the United States Public Health Service Reserve to civilian physicians during such times as they might treat casualties which were the result of belligerent action and at such times as they might treat civilians occupying evacuation areas, and

*Whereas*, These physicians, by virtue of such commission in the U. S. Public Health Service would be under the jurisdiction and beholden for assignment, remuneration and promotion to a Federal agency, and

*Whereas*, The Physicians of New Jersey always have been and may always be depended upon to render services to those in need or distress during any emergency, and to fulfill all other obligations of a citizen-physician and member of the medical profession,

*Therefore, Be It Resolved*, That The Medical Society of New Jersey, represented by its House of Delegates, give serious consideration to the advisability of physicians accepting such commissions, except as may be bestowed upon civilian physicians of New Jersey assigned to the necessary administrative duties connected with the Office of Civilian Defense, and then only when the bestowal of such commission is for the purpose of granting the necessary authority to promote the Civilian Defense program.

The following is an extract from the joint memorandum of the Surgeon General, United States Public Health Service and Chief Medical Officer of the Office of Civilian Defense dated March 12th relative to the commissioning of civilian physicians to care for casualties during or resulting from bel-

ligerent action or the care of civilians occupying evacuation areas:

"VIII. With the assistance of State Chiefs of EMS, the Regional Medical Officers will secure applications for commissions in the USPHS Reserve of physicians and dentists who are to be available for active duty in Emergency Base Hospitals or for the care of persons evacuated to reception areas, when ordered by the Surgeon General. (Note: Plans for advising the States with regard to evacuation and reception will be distributed subsequently by the appropriate Federal agencies.)

"Physicians and dentists so commissioned will be retained on inactive status until need for their services arises. Applications will be considered from primarily those in the older age groups, from those with physical impairments which render them ineligible for military service, and from women physicians and dentists.

"The general policy will be to solicit primarily the medical staffs of leading civilian hospitals for this purpose, so that balanced professional units may be available to staff Emergency Base Hospitals, which will be affiliated with large urban hospitals or groups of hospitals wherever feasible. Physicians and dentists in general practice will also be encouraged to apply for reserve commissions. As far as possible, service of such Reserve Officers will be in the area in which they reside.

PRESIDENT LEWIS: Thank you, Dr. Costello. This goes to Reference Committee "A".

Action: Page 20.

Are there any other officers' or committees' reports to be supplemented at this time?

#### HONORARY MEMBERSHIP

DR. WILLIAM J. CARRINGTON: The Committee on Honorary Membership wishes to recommend the name of Dr. Josephine Baker, of Princeton, New Jersey, one of the pioneer pediatricians of this country, and her election as an Honorary Member of this Society is recommended by Dr. Stanley Nichols and your Committee.

PRESIDENT LEWIS: This will be referred to the Reference Committee on Miscellaneous Business.

Action: Page 34.

Is there any other officer or committee wishing to render a report? If not, we will proceed to new business, and in opening that, I am going to give the floor to your President-Elect, Dr. Marsh.

PRESIDENT-ELECT MARSH: Mr. President, I have certain suggestions to make that I would like to see carried out by this Society; however, I do not know how far it is possible to take present action under the existing circumstances, but some of them are what I

consider to be of permanent value, and, as President Lewis said a few moments ago, we must give some thought to what is going to happen in the future. These are largely suggestions that antedate the present emergency, I was going to say—pre-Pearl Harbor, but I think they will have a long post-Pearl Harbor implication, too.

I will do nothing more than read the proposed amendments to the By-Laws to be enacted, to get them before the House of Delegates. They will be referred to the Committee on By-Laws and I will be prepared to discuss them more fully with any of you before that Committee. It is part of a procedure to enable certain work to be done.

Some years ago we had a Committee on Scientific Work. A number of years ago I was a member of that committee and I know something of what the committee was supposed to do. The committee, itself, gradually forgot what its functions were—it was a preliminary program committee, and it was thought unnecessary, so it was abolished, but there are many useful functions for such a committee to perform.

I should like to offer the following amendments to the By-Laws:

#### AMENDMENTS PROPOSED TO THE BY-LAWS

##### CHAPTER VIII

Sec. 2: After "Committee on Finance", introduce "Committee on Scientific Work".

After Section 5, insert "*Section 6—Committee on Scientific Work.*"

The Committee on Scientific Work shall consist of one member from each Councilor District, chosen by the House of Delegates, one term expiring each year in rotation, and two members appointed by the President, one term expiring each year; it shall choose its own chairman and secretary.

The duties and functions of this committee shall be:

a. To collect information, through the county reporters or otherwise, of members who are interested in prosecuting scientific studies or research, privately or in hospitals, schools, health departments, or other agencies in the State;

b. To support and encourage such work, as means and opportunity may be available, and in general to promote interest in original scientific work among the members of the Society;

c. To facilitate contacts and exchanges between workers in related fields in different parts of the State;

d. To facilitate the presentation of such work and its results to the Society, either at its meetings, through the committees in charge, or in the *Journal*, through the Publication Committee."

Amend Section 6

By renumbering it as Section 7.

By changing the period after "five members" at

the end of the first sentence into a comma, and adding: "with the President and Secretary ex-officio."

By striking out all after the first paragraph, and substituting therefor the following: "The committee may arrange itself into such subcommittees as it deems most conducive to the efficient performance of its functions. It shall have entire charge of the program and all arrangements for the sessions, scientific and technical exhibits, and other features of the annual meeting and associated functions, subject to the directing control of the House of Delegates, and of the Board of Trustees, to which it shall report its plans, for approval. But in planning the scientific features of the meeting, preference shall be given to the work of members of this Society, and special prior preference to the recommendations of the Committee on Scientific Work. Free discussion of all presentations shall be reasonably encouraged."

Renumber the remaining sections of Chapter VIII, by adding one to each number.

#### CHAPTER X

Amend *Section 2*, by adding:

"Each county society shall cause its secretary to transmit to the Executive Office of this Society, as promptly as may be, an abstract of the proceedings or minutes of each regular or special meeting."

Strike out *Section 7*, and substitute the following:

*Section 7—Reporters.* Each county society shall choose a reporter, whose duty shall be to collect information on epidemics or other public health matters, hospital news of general interest, reports of research or scientific studies by members, unusual clinical cases, and similar items, and to report them to the committees on Publication and on Scientific Work of The Medical Society of New Jersey. And these committees shall report jointly to the House of Delegates each year the names of reporters who have done meritorious work, proportionate to their respective opportunities.

The purpose of these amendments I shall be glad to present to the House on Thursday morning, or to present it to the Committee on By-Laws.

PRESIDENT LEWIS: Do you wish to have this considered as first reading of these proposed amendments?

PRESIDENT-ELECT MARSH: Yes.

PRESIDENT LEWIS: They will be so considered and will be referred to the Reference Committee on Constitution and By-Laws.

Action: Page 32.

PRESIDENT-ELECT MARSH: The program I have in mind for the coming year, the administrative program, is based, first, on the prosecution of the military effort of the country and the responsibility of the medical profession of this State in relation thereto. Everything else emphasized by the President is subordinate to that aim. How much opportunity or how

much energy we will have left for anything else remains to be seen.

The next matter of importance to see to successful completion or, at least, to carry much farther on its way, is the work of the Medical Service Administration and its allied services. This we have to do.

#### ADMINISTRATIVE PROGRAM—1942-43

##### PROJECTS

I. *Committee on Scientific Work* to be restored, with these functions:

1. To collect information through the county reporters or otherwise, of members who are prosecuting scientific researches or studies in the State, in hospitals and similar institutions, in schools, in public health departments or other agencies, or in private, or of any who wish to undertake such studies.

2. To support and encourage such work, as means and opportunity may be available.

3. To facilitate the presentation of such work and its results, either

a. at the Annual Meeting, through the Annual Meeting Committee, or

b. in the *Journal*, through the Publication Committee.

4. To facilitate contacts between workers in related fields in different parts of the State.

5. In general, to promote interest in original scientific work, by the members of the Society.

##### II. *County Reporters*

1. To return to their original and proper function of

a. Collecting information on matters of professional interest in their respective counties, such as unusual clinical cases, hospital news of general interest, epidemics or other public health matters, original investigations, and similar items of medical (not personal) news, and

b. Reporting such items to the committees on Publication, Scientific Work, Welfare, Public Health, or other appropriate agency.

2. Provision for the selection of suitable persons for this function, and for the recognition of good work by them.

##### III. *Graduate Education*

1. Organization of this activity largely on the basis of discussion groups, with selected members of our own society as leaders, and every member encouraged to take an active part, instead of lectures by outsiders to passive listeners.

2. Development of every hospital in the State as a teaching hospital, for

a. The stimulating effect on the staff;

b. The resultant benefit to the patients;

c. The diffusion of the best scientific technique among the nonhospital members of the profession.

IV. More active participation of the general membership in the scientific programs and organizational business of the county and state societies, in respect of both

a. Presentation of topics, and

b. Free discussion, as becomes a liberal and



democratic profession, in contrast with a dictatorial and dogmatic discipline.

V. Establishment of an *Endowment Fund*, for the support and encouragement of original investigations by our members, to compensate for the lack of any generally available teaching or research institution in the State. We have in New Jersey plenty of ability, plenty of the scientific spirit, and plenty of material, clinical or other, for good original work, but no facilities for practically bringing them together in a fruitful way. Also, in spite of depression, taxes, and war, there are still a few dollars remaining in the State that might be trapped and put to useful work of this sort, if the matter can be skillfully arranged—not all at once, but in time.

From 1776 and even long before, until long after this present war is forgotten—the first interest of medical men has been and will be scientific work. Our function in relation to the war, and also in relation to the purpose of the Medical Service Administration, is to facilitate the distribution and application of medical science in the place where it is most needed at the time. Our prime interest in the actual development of medical science at times is hampered by more urgent if not more important things.

As long ago as December, 1861, in the midst of the Civil War, the President of Harvard wrote these words in his annual report:

"One of the greatest evils of war is the check it almost invariably puts to the progress of science and civilization; but they serve their country who continue toiling in the discovery of truth and the education of the young, no less than those who arm themselves for the field of battle."

The purpose that I have in mind, and it will also be a long post-Pearl Harbor purpose, is to stimulate the scientific interest and the scientific work of the members of this Society at home.

Those by-laws that I have just proposed are in part for the purpose of aiding in that work.

Also I wish, as far as it may be practicable now or in the future, to suggest certain developments in graduate education to be referred to the Committee on Graduate Education, i. e.: (1) The organization of this activity on the basis of discussion groups, led by selected members of our own society. (2) That every member be encouraged to take an active part, instead of listening to lectures given by outsiders.

A professor of a well-known medical school wrote me recently: "It is always possible to get prominent speakers from outside. They like to come and are glad of the opportunity, but it is always difficult to interest a good

many of our own members who should take part in the work of their societies. They would rather sit in the back of the room and listen."

You cannot learn to do surgery by watching some other fellow operate. You must take the knife in your own hand. You cannot learn to write prescriptions by reading prescriptions in a book. You have to learn to adapt your own prescription to your particular case—the same procedure is required in scientific work. You have to profit from your own interest and your own investigation, not necessarily in the laboratory. Even if it requires nothing more than looking up and discussing and listening to and sharing in some other person's presentation, you must take an active part in it.

In addition, I should like to encourage the development of every hospital in the State as a teaching hospital, because of the stimulating effect on the staff; the resulting benefit to the patients; and the discussion of the best scientific technic among the non-hospital staff members in the profession.

I should also like to encourage, as Dr. Lewis himself has suggested, the establishment of an endowment fund, for the support and encouragement of original investigations conducted by our members. This would compensate for the lack of any generally available teaching or research institution in our State. We have in New Jersey plenty of ability, plenty of the scientific spirit, and plenty of clinical and other material to produce good original work; but we lack facilities for bringing them together in a practical and fruitful way. In spite of depression, taxes, and war, there are still a few dollars remaining in the State which might be put to useful work of this sort, if the matter can be skillfully arranged—not necessarily at once, but in due time.

You may know of some patient now buying Defense Bonds. Those bonds have to be made payable to somebody, and if you know somebody buying \$25 bonds for \$18.75, or a \$1000 bond for \$750, or who has something else of value, and would like to write in the name of the Treasurer of The Medical Society of New Jersey as beneficiary, a few dollars might be accumulated twelve years from now that could be used for this purpose.

I do not know how many of your patients would be enthusiastic about doing this. The suggestion may be more for the future than the present, but the general picture I would like to leave for you, to bear in mind for future development is the increase and encouragement of original scientific work done by our own members in our own institutions, and the provision of such opportunities.

PRESIDENT LEWIS: Thank you, Dr. Marsh. This portion of Dr. Marsh's presentation will be referred to Reference Committee "A".

**Action: Page 20.**

We come now to New Business and inasmuch as there will be no discussion at this session, we recommend that all new business be presented in the form of resolutions in so far as possible.

I will now call on members for presentation of resolutions.

#### RESOLUTIONS

DR. DAVID B. ALLMAN: The Atlantic County Medical Society has a resolution it wishes to present.

*Resolved*, That the Atlantic County Medical Society recommends to the House of Delegates the adoption and passage of legislation for Annual Registration.

PRESIDENT LEWIS: This resolution will be given to the Committee on Resolutions.

**Action: Page 26.**

DR. WELLS P. EAGLETON: I speak as the senior member present at this meeting and as a Delegate to the A. M. A. from our Society.

1. We, The Medical Society of New Jersey, the oldest State Medical Society in the Western Hemisphere, who have held continual Annual Meetings since 1766 excepting during the American Revolution when more than a majority of our members were in the active military service of our country, pledge our wholehearted support to the President and Government of the United States and to the successful prosecution of the war, and the establishment of a new and better order, based on justice and the dignity of all our people without exception, irrespective of race, color, nationality or creed, for President Roosevelt is our President. He and his Cabinet, and the United States Congress are our Government, and *this is our war*.

2. Speaking for over 4000 of the 5000 physicians legally licensed to practice medicine in New Jersey, we would make the following statement:

We are pleased and congratulate the American Medical Association for the aid it has given our Government in the enlistment of physicians in our armed forces, and for civilian defense, acknowledged in a letter by Assistant Secretary of War Paterson, recently published in the Journal of the American Medical Association.

3. We hope that this service, aiding our Government in obtaining doctors for armed forces and in civilian defense, in which we in New Jersey have cooperated to the best of our ability, will act as a bridge to harmonize any unhappy differences which

may have existed between organized medicine in America and our Government.

4. We regard it as the duty of the organized medical profession to take the lead in all matters pertaining to the health of our people.

5. We recognize the necessity for a revision in the present method of distribution of medical care. For although the need of drastic alterations in New Jersey is not so urgent as in some other states, still we believe that a national health program should be formulated, so that the one-third of the total of our people who today cannot pay a doctor may obtain adequate medical care.

6. We in New Jersey are especially qualified to aid in such a plan because of our experience with the E. R. A. and in the organization of the Medical Service Administration.

7. We instruct our Delegates to the Convention of the American Medical Association to advocate a national health program based on the accumulated experience.

PRESIDENT LEWIS: This resolution will be referred to the Reference Committee on Resolutions and Memorials.

**Action: Page 25.**

DR. NORMAN W. BURRITT: Mr. President, I wish to introduce, by title only, a piece of business, the facetious title of which is "This Is the House That Jack Built" and which now resides in a subcommittee of the Board of Trustees.\*

PRESIDENT LEWIS: I will refer this matter to the Reference Committee on Miscellaneous Business.

**Action: Page 34.**

DR. WENDELL J. BURKETT: By way of instruction from the Chair, do I understand only the resolutions presented at this session are to be considered by the Committee on Resolutions—that no other resolutions will be received later?

PRESIDENT LEWIS: Yes, at this time only. It would otherwise be pretty difficult to get them before the Reference Committee.

If you wish to hold an additional meeting, I think that would be up to the Chairman of the Committee, who should publicize the time and place.

Are there any other resolutions to be offered to the House of Delegates?

Is there any other new business to be brought forward at this time? If not, I will declare the House recessed until noon tomorrow.

The House recessed at 12:40 p. m.

\* Copy in Executive Office file.

## WEDNESDAY NOON, APRIL 22, 1942

The second session of the House of Delegates convened at 12:30 p. m. President Lewis presided.

PRESIDENT LEWIS: The House will come to order. the convention, is the Election of Officers. I will call upon the Secretary of the Nominating

According to the Constitution, the first order of business at this meeting, the second day of Committee, Dr. North, to render his report.

### REPORT OF NOMINATING COMMITTEE

The Nominating Committee begs to submit the following nominations:

OFFICE	TERM	NOMINEE
President-Elect	1 year	Ralph K. Hollinshed
First Vice-President	1 year	Joseph F. Londrigan
Second Vice-President	1 year	Samuel Alexander
Secretary	1 year	Alfred Stahl
Treasurer	1 year	George J. Young
Trustees	3 years	James F. Norton (at large)
	3 years	Thomas B. Lee (4th District)
	3 years	Harry R. North (3rd District)
	3 years	David W. Green (5th District)
Councilors	3 years	Christopher C. Beling (1st District)
	3 years	S. Emlen Stokes (4th District)
A. M. A. Delegates	2 years (1943-1944)	Wells P. Eagleton
	2 years (1943-1944)	Hilton S. Read
	2 years (1943-1944)	Thomas K. Lewis
A. M. A. Alternates	2 years (1943-1944)	Elmer P. Weigel
	2 years (1943-1944)	Lancelot Ely
	2 years (1943-1944)	Clarence W. Way
Delegate to Connecticut	1 year (1943)	C. Byron Blaisdell
Alternate to Connecticut	1 year (1943)	William G. Herrman
Finance and Budget Committee	6 years	Herschel Pettit
Publication Committee	3 years	Henry C. Barkhorn

PRESIDENT LEWIS: You have heard the report of the Nominating Committee.

DR. HILTON S. READ: I move that the nominations be closed and the Secretary cast the ballot of the House of Delegates.

The motion was regularly seconded.

PRESIDENT LEWIS: Is there any discussion? These are nominations. It is the privilege of any member to propose nominations from the floor. Are you ready for the question?

The question was called for, and the motion was put to a vote and *was carried*.

PRESIDENT LEWIS: I declare the nominees as presented by the Nominating Committee are duly elected for the respective offices. It is so ordered.

Unless there is some question or offering from the floor, this House of Delegates will recess until ten o'clock tomorrow morning.

The House recessed at 12:45 p. m.



**Thursday Morning Session, April 23, 1942**

The third session of the House of Delegates convened at 10:00 a. m. President Lewis presided.

PRESIDENT LEWIS: The House will come to order.

**REFERENCE COMMITTEE "A"**

We will proceed at once to the reports of Reference Committees. I will call on the Chairman of Reference Committee "A" for a first report.

DR. C. BYRON BLAISDELL:

This Committee has the honor to report upon the annual reports of the President, the President-Elect, the Board of Trustees, the Secretary, the Judicial Council and the Executive Officer. The Committee met at 8:00 p. m. Present were: the Chairman and Drs. Butler, Mason and Comando. Dr. Okin telegraphed his inability to be present.

**Report of the President**

The report of the President (see page 5) was taken up first and was given unqualified approval. The Committee felt that the President had set forth a program in taking on the duties of his office, had declared that program to a special meeting of the sub and advisory committees, and in this report has shown the continuation of that program, which was designed to meet the needs of this war-time emergency. This report is recommended to the House of Delegates for adoption.

I move its adoption.

PRESIDENT LEWIS: You have heard the motion concerning the first portion of this report. Do I hear that seconded?

The motion was regularly seconded and *was carried*.

DR. BLAISDELL:

**Report of the President-Elect**

The Committee approves in principle Dr. Marsh's report (see page 187, April *Journal*) as being devoted to the ideals of medicine, to the development of the Society, to the advancement of scientific work, and to a revitalization of the scientific and organizational business of both State and County Societies. Much of this report is forward-looking and there is nothing which the Reference Committee feels can not be approved. The recommendation that the office of President-Elect be abolished and the offices of First, Second and Third Vice-Presidencies be reestablished, was discussed in committee, and Dr. Marsh pointed out that this is submitted for study during his administrative year. On this basis the Committee has approved of the report as a whole and moves its adoption.

The motion was regularly seconded.

PRESIDENT LEWIS: It has been regularly

moved and seconded that the second portion of this report be adopted. Is there any discussion?

The motion was put to a vote and *was carried*.

DR. BLAISDELL:

**Report of the Board of Trustees**

The report of the Board of Trustees (see page 185, April *Journal*) offers no controversial points which the membership has not been able to consider adequately, and the procedures of the Board during the year have been timely and unquestionably devoted to the best interest of the Society. A supplementary report of the Board was discussed in committee and Dr. Costello appeared as Chairman for the Board of Trustees.

The recommendations of the abandonment of the Fall Clinical Conference and the return of the details of the work of the Public Relations Committee to the Executive Offices under the supervision of the Chairman of the Public Relations Committee were obviously in the interest of economy, as well as the temporary transfer of the work of the Editor to the Executive Officer.

The Trustees offered one resolution which it is understood will be open to discussion on the floor of the House of Delegates. (See page 14.)

After conference with Dr. Schlichter, this Committee feels that the resolution is offered in defense of the maintenance of the physician in private practice and knowing that the Chief Medical Officer of the Office of Civilian Defense for New Jersey is willing to speak for the presentation of this resolution, the Committee therefore approves it and recommends the report of the Board of Trustees for adoption.

I move its adoption.

PRESIDENT LEWIS: Is it your wish to act independently upon the resolution or upon Section 3 of this report *in toto*, including the resolution?

DR. SAMUEL A. COSGROVE: Perhaps it would clarify the matter if we would transfer discussion of this recommendation of the Board of Trustees to a more fitting place in this morning's program, and expedite this committee's report to *amend the motion that the Reference Committee's report be accepted with the exception of such part of it as pertains to the resolution*.

PRESIDENT LEWIS: Is that amendment seconded?

DR. CHESTER I. ULMER: I second the motion.

PRESIDENT LEWIS: Do you agree to that?

DR. BLAISDELL: Yes, sir.

PRESIDENT LEWIS: The motion as amended is that portion three of the report be adopted, with the exception of that portion on commissioning physicians in the Public Health Service.

The question was called for and the motion was put to a vote and *was carried*.

DR. BLAISDELL:

#### Report of the Secretary

The annual report of the Secretary (see page 7) is brief, concise and represents faithful and conscientious discharge of the duties of the office, and is moved for adoption.

The motion was seconded.

PRESIDENT LEWIS: It is regularly moved and seconded that this fourth section of this report be adopted.

The motion was put to a vote and *was carried*.

DR. BLAISDELL:

#### Report of the Judicial Council

Four out of five of the Councilor Districts report that no problems have been presented during the year. The Fifth Councilor District reports the continuation of a program aimed to promote the solidarity of the State organization through closer contact with the counties of its district. This is perhaps commendable as such, but the Committee feels that the function of the five Judicial Councils are not used adequately by the membership, and the value, therefore, is not being exercised to the fullest degree. There must be many problems of individual members within county societies in which the Judicial Councilors would be valuable, both for their opinion and also for providing an opportunity of airing grievances or difficulties which may otherwise lie submerged. This Committee moves the adoption of the report of the Judicial Council.

The motion was seconded.

PRESIDENT LEWIS: It is moved and seconded that Section 5 of this report be approved and adopted.

The motion was put to a vote and *was carried*.

DR. BLAISDELL:

#### Report of the Executive Officer

The report of the Executive Officer (see page 188, April *Journal*) was considered carefully. The report is commended for its manner of presentation, its awareness of the necessities for making more efficient the administration of the office, and its aim toward economy. Insofar as it urges the membership to understand the benefits of the Medical Service Administration, it shows therewith the present inadequate appreciation of the benefits to be derived and the need for some further method of presentation in simple form to the members at

large, so that the plan may become more universal. The Reference Committee moves the adoption of this report and expresses its appreciation to the Executive Officer and his staff for the prompt and accurate supply of information necessary to the consideration of the various reports of committees and officers.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. BLAISDELL: I move the adoption of the report as a whole, with the exception of the resolution pertaining to Public Health Service which is to be further discussed.

The motion was regularly seconded, was put to a vote, and *was carried*.

#### REFERENCE COMMITTEE "B"

PRESIDENT LEWIS: I will now call for the report of Reference Committee "B".

DR. HILTON S. READ:

Your Reference Committee "B" met at the appointed place and hour with a complete attendance of its appointed personnel. There appeared before the meeting the Chairman of the Finance and Budget Committee, the State Treasurer and a President of a County Society. No other members appeared and no communications were addressed to the Committee other than those referred from the House of Delegates.

I move the adoption of this portion of the report.

DR. ULMER: I second the motion.

The motion was put to a vote and *was carried*.

DR. READ:

#### Publication Committee Report

Your Committee carefully studied the report of the Publication Committee as submitted by Dr. Barkhorn, the Chairman (see page 193, April *Journal*). The report of this Committee is approved.

Your Reference Committee was unanimous that appropriate commendation should be extended to the Publication Committee for the literary excellence of its product and the fruitful economic results of its efforts. It was the considered opinion of the Reference Committee that few Publication Committees throughout the country could equal the record of the Publication Committee of The Medical Society of New Jersey in these two respects.

Your Reference Committee notes the resignation of Dr. Overton as referred to in the report of the Publication Committee. We wish to pay tribute to this sterling gentleman and in the name of the Society record our deep appreciation of the six pleasant years Dr. Overton spent in the service of The Medical Society of New Jersey in the record of this House.

Your Reference Committee also wishes to add a note of commendation to the Publication Committee in its choice of Dr. Henry A. Davidson to be his successor. In the few short months he occupied the Editor's chair before being called into military service he added new lustre and injected new vitality into an already sparkling publication. We miss him and look forward to the pleasant peaceful days when he returns.

I move the adoption of this portion of the report.

The motion was regularly seconded, was put to a vote and *was carried*.

DR. READ:

#### Treasurer's Report

Your Reference Committee "B" carefully studied the report of the Treasurer (see page 7), who was present to answer the many questions fired at him. His ready response showed a complete and intimate knowledge of the finances of the Society. He was able to answer each question to the complete satisfaction of the inquisitor. Your Committee wishes to go on record as being of the opinion that this Society is unusually fortunate in its choice of a Treasurer and further wishes to go on record commending the Board of Trustees, the Executive Offices, and all committee members whose cooperation made possible the considerable savings in the cost of operation of the Society for the past year without any dilution in its effort or effect.

We approve the report of the Treasurer.

I move the adoption of this portion of the report.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. READ:

#### Report of the Finance and Budget Committee

Your Reference Committee "B" studied in detail the report of the Finance and Budget Committee (see page 8), as presented in the form of budget appropriations for 1942-1943, showing a total of \$73,418.00. Only two items have been increased in allotment, namely an increase of \$200.00 to the Committee on Legislation and an increase of \$6,000.00 to the Medical Service Administration.

We approve the report of the Finance and Budget Committee.

I move the adoption of this portion of the report.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. READ:

#### Dues for 1943

Your Committee was informed by the Chairman of the Finance and Budget Committee that it has anticipated that 1,000 members, or 25 per cent of the total roster, will be in the armed services. If, as it is anticipated, you approve the remission of

their dues, this will throw a considerable financial load on the budget. In other words, three thousand and will have to pay what four thousand members would ordinarily pay. It was felt perfectly just that those who stay at home should pay the freight. It is thought that if there is present the continued cooperation of those, who last year effected a saving in the budget, and if the Medical Service Administration does not draw unduly heavily on the budget, the present budget will meet all demands for next year.

The suggestion of the Finance and Budget Committee, the Treasurer, and the Board of Trustees, that the dues for 1943 be \$17.00 per member (actually it figures to \$16.91) is approved, with one of our members dissenting. The member from Mercer County suggested that the dues for 1943 be \$20.00 as there is already a considerable deficit in our usual \$20,000.00 backlog and as the number of members remaining at home and paying dues is unpredictable, and as it may be necessary during the war years to make much larger increases unless this suggested increase is approved at this time.

I move the adoption of this portion of the report.

The motion was regularly seconded.

PRESIDENT LEWIS: In your report you do not indicate whether you approve of the minority report or the majority report.

DR. READ: I simply added the minority report parenthetically. "The suggestion of the Finance and Budget Committee, the Treasurer, and the Board of Trustees, that the dues for 1943 be \$17 per member, is approved."

The motion was put to a vote and *was carried*.

DR. READ:

#### Remission of Dues

The following resolution as submitted in the Supplementary Report of the Trustees (see page 14) was referred to this Committee for consideration:

Resolved, That the Society go on record to pay the dues, either by remission or credit, of all members serving full time in the armed forces and so certified by the President and Secretary of their respective County Society, up to the time of the 1943 Annual Meeting.

We approve this resolution.

I move its adoption.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. READ: This report is respectfully submitted, and I move the adoption of it as a whole.

The motion was regularly seconded, was put to a vote, and *was carried*.

#### REFERENCE COMMITTEE "C"

PRESIDENT LEWIS: I will call on the Chairman of Committee "C", who will present his report.



DR. JAMES F. NORTON: Reference Committee "C" had referred to it two reports, the Report of the Medical Preparedness Committee (see page 213, April *Journal*) and the Medical Service Administration (see page 216, April *Journal*). There was no supplemental report from the Medical Preparedness Committee and we move the adoption of the report as it appeared in the *Journal* (see page 213, April *Journal*), and wish to add that the Society expresses its appreciation and thanks for the very high grade of work done by the Chairman and the members of the Medical Preparedness Committee.

I move the adoption of the report of the Medical Preparedness Committee.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. NORTON: We had a long hearing on the report of the Medical Service Administration and many people appeared before the Committee and discussed it from many angles. The nature of the discussion emphasized, of course, the lack of unanimity concerning the whole project of medical service, of Medical Service Administration, and also tended to emphasize that there are some discrepancies, so we have both a majority and a minority report to submit.

The majority report *approves* the report of the Medical Service Administration, places two recommendations before the House of Delegates, and recommends the approval of these two recommendations.

1. That Medical Service Administration be retained as an active organization for the purpose of continuing operation of the Farm Security Plan and for the study and development of plans to provide medical care for the indigent.

2. We recommend that Medical-Surgical Plan transact business for one year in those counties in which it has been approved by the respective county societies.

We realize there are possible defects in the procedures proposed by these organizations, that there are many things of which we do not have complete understanding, but we do believe that this is a safe approach to guard the rights of the medical profession in the future in an effort to retain control of the affairs of medicine.

We recommend that all counties and all individual physicians lend support to this very important effort for one year so that at the end of a year we will have demonstrated its defects and advantages.

All activities of these organizations have been supervised and approved by your Board of Trustees.

Before I move the adoption of that, is it proper to read the minority report?

PRESIDENT LEWIS: Yes, I would read the minority report.

DR. NORTON: The majority report is signed by E. LeRoy Wood and James F. Norton.

### Minority Report

While deeply appreciative of the tremendous amount of time, energy and self-sacrifice the Committee has put into the preparation of Medical-Surgical Plan the minority feels that war time is not the proper moment to inaugurate such a tremendous social experiment as voluntary health insurance. We feel that with all the best intentions on the part of the Committee and the Board of Trustees, this experiment, starting as insurance for catastrophic illness, once started, will never be stopped but will lead progressively to general health insurance, and eventually to compulsory health insurance.

We believe that already enough counties have agreed to try the Plan to give the experiment an adequate trial and recommend that no further efforts be made to extend the movement into other counties for another year.

Mr. President, I move the adoption of the majority report.

The motion was regularly seconded.

PRESIDENT LEWIS: Dr. Norton, there are two recommendations in that report. I think it might be wise to act upon each recommendation.

Let's act on the first recommendation.

DR. NORTON: "That Medical Service Administration be retained as an active organization for the purpose of continuing operation of the Farm Security Plan and for the study and development of plans to provide medical care for the indigent."

I move the adoption of that recommendation.

The motion was regularly seconded.

PRESIDENT LEWIS: It is regularly moved and seconded that this recommendation be approved. Is there any discussion?

The motion was put to a vote and *was carried*.

DR. NORTON: I move the approval of the second recommendation: "We recommend that Medical-Surgical Plan transact business for one year in those counties in which it has been or will be approved by the respective County Societies."

The motion was regularly seconded.

DR. FREDERIC J. QUIGLEY: There is one question I should like to ask. Incorporated in the report or the recommendation, "that it be tried in the respective counties, by the respec-

tive County Societies where it has been or will be approved", is the question as to method of approval. This is very important.

Under the legislative act setting up the Medical Service Administration, it is very definitely stated that these various plans which the Medical Service Administration may operate shall operate "only in counties where 51 per cent of the physicians in the county have agreed to accept it".

Now, what is the meaning of the recommendation "in the counties where it is approved"? Does that mean that it shall be approved *at a meeting of the County Society*, or does it mean *when 51 per cent of the physicians in that county have expressed approval by signing the agreement?*

PRESIDENT LEWIS: Legally it may operate in any county in which 51 per cent of the physicians have indicated their willingness to coöperate; however, as a further proof of the good faith of the Committee which has advocated this whole program, as a moral obligation they have agreed not to attempt to sell this contract in any county where the County Medical Society has not approved it as a body.

Does that answer your question, Dr. Quigley?

DR. QUIGLEY: Yes, it does.

PRESIDENT LEWIS: All those in favor of Dr. Norton's Committee's motion indicate by saying "aye"; those opposed, "no". It is *carried*.

DR. NORTON: I move the adoption of the Committee's report *in toto*.

The motion was regularly seconded, was put to a vote and *was carried, with one dissenting vote*.

#### BOARD OF TRUSTEES' SUPPLEMENTARY REPORT

PRESIDENT LEWIS: Dr. Costello, have you a supplementary statement from the Board of Trustees?

DR. WILLIAM F. COSTELLO: The Board of Trustees met yesterday afternoon and offers this report.

The matter of commissioning medical personnel for the care of the civilian population by the United States Public Health Service was referred to a subcommittee of the Trustees and the following report has been rendered. This report was unanimously approved by the Trustees.

At the present time we see no need for the commissioning of medical personnel for the care of the civilian population by the United States Public Health Service, as described in paragraph 8 of the joint memorandum from the Surgeon General of the United States Public Health Service and the

Chief Medical Officer, Office of Civilian Defense under date of March 12, 1942.

THOMAS B. LEE, M.D.

GEORGE J. YOUNG, M.D.

RALPH K. HOLLINSHED, M.D.,

Chairman

I move the adoption of this portion of the report.

PRESIDENT LEWIS: That subject was also included in a portion of the report of Reference Committee "A". We will not act upon it at the present time. Will you hand that portion over to the Resolutions Committee?

DR. COSTELLO: Another report was given to us.

Dr. Burritt's complaint to the Trustees was referred to a subcommittee of the Trustees and the following report was rendered. This report was unanimously approved by the Trustees.

The Committee reports that it has not had sufficient time to study the material submitted to justify further action than has already been taken.

This is a report relating to the Pure Food and Drug Act, and to the Winthrop Chemical Company and some other matters.

I might say that a subcommittee of the Board; the Welfare Committee (a year ago); and our Board of Trustees have studied this question and each came in with a report.

I move the adoption of this report.

The motion was regularly seconded, was put to a vote, and *was carried*.

#### REFERENCE COMMITTEE "D"

PRESIDENT LEWIS: I will now call on the Chairman of Reference Committee "D".

DR. HAMMELL P. SHIPPS: Mr. President and Members of the Society: Reference Committee "D" met at the appointed time and found that our duly appointed Chairman, Dr. Gamon, was detained at home on account of illness. We appealed to our President for further assistance. He appointed Dr. Marcus W. Newcomb to our Committee, and the Committee members present made Dr. Newcomb Chairman of the Committee.

Dr. Newcomb is not here this morning and has asked me to present the Committee's report.

1. *Welfare Committee Report*. (See page 196, April Journal.)

We recommend that due to the war a number of the advisory committees of the Welfare Committee be combined.

DR. SHIPPS: I move the adoption of this portion of the report.

DR. READ: I second the motion.

The motion was put to a vote and was carried.

DR. SHIPPS:

2. Post-Graduate Education Report (see page 195, April *Journal*).

The report of this Committee was approved.

I move the adoption of this phase of the report.

The motion was regularly seconded, was put to a vote, and was carried.

DR. SHIPPS:

3. Medical Defense and Insurance Committee Report. (See page 191, April *Journal*. Supplementary report, page 10 of these Transactions.)

The report of this Committee was approved.

I move the adoption of that portion.

The motion was regularly seconded, was put to a vote, and was carried.

DR. SHIPPS:

4. Report of the State Board of Medical Examiners (see page 217, April *Journal*).

The question of annual registration was considered and in view of the evidence pro and con as presented by the various members of the Medical Society, it was unanimously disapproved by the Reference Committee.

We recommend that the Board of Trustees give careful consideration to the problems of the State Board of Medical Examiners. We also recommend a closer coöperation between the Board of Medical Examiners and the State and County Medical Societies; for instance, each member is urged to report all illegal practitioners and infractions of the Medical Practice Act.

I move the adoption of this portion of the report.

DR. READ: Might we table that portion of the report (regarding Annual Registration) and take it up later?

PRESIDENT LEWIS: Do you so move?

DR. READ: I do.

The motion was regularly seconded.

PRESIDENT LEWIS: It has been moved that the fourth portion of this report be tabled until the time of the discussion of the resolution on this matter to be presented by your Reference Committee on Resolutions.

The motion was put to a vote and was carried.

DR. SHIPPS: I move the adoption of this report in its entirety except for the fourth portion, which is tabled.

The motion was regularly seconded, was put to a vote, and was carried.

#### COMMITTEE ON CREDENTIALS

PRESIDENT LEWIS: Next is the Report of the Reference Committee on Credentials, Dr. Marsh, Chairman.

DR. ELIAS J. MARSH: No contests have been brought to our attention, and our authority is confined to disputes on the credentials of members of the House of Delegates. We had no disputes. I move the adoption of this report.

The motion was regularly seconded, was put to a vote, and was carried.

#### REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

PRESIDENT LEWIS: Dr. Burkett, will you present the report of the Reference Committee on Resolutions?

DR. BURKETT:

The first resolution considered was that offered by Dr. Eagleton. Dr. Eagleton commented upon the resolution and offered suggestions as to the adoption of the same, stating that the intent of the resolution was that our delegates from the State Society present to the House of Delegates of the A. M. A. the plan of a national health program to be proposed by the A. M. A.

The Chairman of this Committee failed to ask for any comment opposed to this resolution when Dr. Eagleton had finished his remarks. It is to be noted that at the close of the Committee's hearing a number of the doctors came to the Chair and voiced their opposition to this resolution.

The action taken by the Resolutions Committee on Dr. Eagleton's resolution is as follows:

We feel that this resolution in part contains ideas of merit for consideration, but that there are other sections which are of a highly controversial nature. We therefore submit this resolution to the House of Delegates without a definite recommendation.

I shall read this resolution, and, Mr. President, if it meets with your approval, I would think that the resolution should be acted upon as its various sections are presented.

PRESIDENT LEWIS: I suggest you read the resolution *in toto* first.

Dr. Burkett read Dr. Eagleton's resolution (see page 18).

DR. BURKETT: Mr. President, the Committee presents this resolution without recommendation.

PRESIDENT LEWIS: Will you read Section 1?

Dr. Burkett read section 1.

DR. RALPH K. HOLLINSHED: If I am not out of order, I should like to suggest that this whole resolution, instead of being acted upon



today by the House of Delegates, he referred to the Board of Trustees for more complete study and revision, and that the House of Delegates give the Board of Trustees the power to carry out the intent of the resolution.

DR. COSGROVE: I move in the terms of Dr. Hollinshed's suggestion, for reference of this whole matter to the Board of Trustees with power.

The motion was regularly seconded.

PRESIDENT LEWIS: Is there any discussion?

The question was called for.

PRESIDENT LEWIS: It has been regularly moved and seconded that this whole resolution be submitted to the Board of Trustees with power to act.

The motion was put to a vote and *was carried*.

DR. BURKETT: The Radiological Society of New Jersey presented to the Chairman this morning the following:

At the annual meeting of the Radiological Society of New Jersey, held at Haddon Hall on April 22, the following resolution was passed:

"The members of this society are in favor of the continuation of the investigation of Plan I, which was to include services of radiologists, and are unalterably opposed to the present Medical Surgical Plan, designated as Plan II."

This was unanimously passed by the Radiological Society of New Jersey.

HARRY PERLEERG, M.D., Secretary,  
Radiological Society of New Jersey.

This resolution passed by the Radiological Society of New Jersey, having been presented after the meeting of the Resolutions Committee, is offered without comment.

PRESIDENT LEWIS: Dr. Burkett, was that offered as a resolution to the House of Delegates, or simply for the information of the House of Delegates, as a resolution emanating from the Radiological Society of New Jersey?

DR. BURKETT: The resolution emanates from the Radiological Society, and to the gentleman who handed it to me I said I would be glad to read it before the House of Delegates.

PRESIDENT LEWIS: Is it offered to be passed upon by this House or as an expression of the stand of the Radiological Society?

DR. BURKETT: As an expression of the Radiological Society of New Jersey.

DR. QUIGLEY: May I make a point of order? As the Chair is undoubtedly aware, this not having been introduced at the first meeting of the House of Delegates would have to come in as new business. Its consideration at this meeting would require unanimous consent of the House of Delegates.

PRESIDENT LEWIS: In addition, it seems as it is presented, to be a resolution passed by the radiologists. You have already approved the perpetuation of the Medical Service Administration. In another resolution you approved the operation of the Medical-Surgical Plan of Medical Service Administration in those counties that have or will have approved its functioning. Do you wish to act upon this resolution or simply to accept it as a communication?

DR. SPRAGUE: I move that the resolution be received and the information be referred to the proper committee.

The motion was regularly seconded.

PRESIDENT LEWIS: It is regularly moved and seconded that this resolution be received and transmitted to the proper committee.

The motion was put to a vote and *was carried*.

DR. BURKETT: The resolution offered by the Atlantic County Medical Society, relative to annual registration caused a great deal of discussion by both the opponents and the proponents.

Resolution 2, offered by the Atlantic County Medical Society relative to annual registration.—This resolution caused a great deal of discussion both by the opponents and proponents, which number at the Committee hearing seemed to be about equally divided. The Committee feels that this very important matter should be decided on the floor of the House of Delegates, but in presenting our report we wish to state the following unanimous recommendation as coming from the Committee: namely, that the Committee favors the adoption of this resolution with the proviso that the present assembly bill be amended, to be enacted for a period of the present national emergency, but not exceeding a period of three years.

To bring this very potent question before the House of Delegates, Mr. President, I move the adoption of this section of the report.

DR. ULMER: I second the motion.

PRESIDENT LEWIS: We have with us today Dr. Wegrocki, who is a member of our Society and who has performed yeoman service for this Society in the State Legislature. I should like to entertain a motion from the House that he be given the privilege of the floor at this time.

DR. ULMER: I so move.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. ADOLPH WEGROCKI (Assemblyman from Essex County): My interest in the Annual Registration Bill is this: As Chairman of the Public Health

Committee in the Legislature, it is within the power of such Chairman of any Legislative Committee to have veto power over a bill, and at the request of the Secretary of the Legislative Committee, Dr. Quigley, we sat on the bill, as we express it, in the Assembly, until some action is taken in the State Society.

I would have preferred to underscore the importance of the work that is done by your Committee in the Assembly. I think that I might be as good an example as any other practicing physician who gets into the Assembly and realizes, perhaps for the first time in his professional life, how important contact of organized medicine is in the legislative halls.

With legislation of public health implication amounting to about 10 per cent of all bills, the constant attendance of a representative of the medical profession is tremendously important not only from the viewpoint of protecting the interests of the medical profession but also for public good, and this bill does have a good deal of interest to us in the Legislature.

The dentists, the pharmacists, the optometrists, and similar boards do have annual registration.

At this time the medical profession has, from the legislative standpoint, possibly one of two choices. To either adopt this resolution and the annual registration, or simply drop it. If it is dropped, then the State Medical Examining Board must go to the State House Committee for funds.

The time for appealing to the House of Assembly, where all revenue bills must originate, is already passed.

We are all aware of the difficulties in making a decision. It has been a principle with us and with the allied medical professions that the policy of dedicated funds and the policy of separate, independent boards has in the past served our interests best.

A suggestion has been made of a compromise. That compromise is possible through a simple procedure of sending out a committee substitute and putting it on the floor of the House for action, if you so desire.

PRESIDENT LEWIS: Thank you, Dr. Wegrocki.

Before opening this subject for general discussion, I want to call on Dr. Shipps to reread that portion of the Report of his Committee with reference to this matter. Dr. Shipps, will you read that?

DR. SHIPPS: I might say the members of the Committee came to the meeting with an open mind and listened to the arguments, and tried to reach a decision from the arguments presented to the Committee. This is our report:

"The question of annual registration was considered and in view of the evidence, pro and con, presented by the various members of the Medical Society, it was unanimously disapproved by the Reference Committee.

"We recommend that the Board of Trustees give careful consideration to the problems of the State Board of Medical Examiners. We also recommend a closer cooperation between the Board of Medical Examiners and the State and County Medical Societies. Each member is urged to report all illegal practitioners and all infractions of the Medical Practice Act."

PRESIDENT LEWIS: Thank you, Dr. Shipps.

This subject is now open for general discussion.

DR. FRANK BIEN (Essex County): For what and why are these funds to be raised?

PRESIDENT LEWIS: I will call on Dr. Hallinger, a member of the Board of Medical Examiners, to answer that.

DR. EARL S. HALLINGER: Mr. President and Members of the Society: This question of annual registration is a very serious one. We are confronted with a situation that has not confronted us since the Board has been in existence.

As you know, the major part of our income comes from the endorsement of licenses from other states. The income that we receive from the conduct of examinations barely pays its way. The greater the number to be examined, the greater the cost.

We have been self-supporting and we have never asked the state to give us funds; we have, in fact, always opposed that because we have been submitted to pressure time and time again to permit individuals to have a license when they are not qualified to have one, and we have always opposed doing away with dedicated funds because as a situation arises where we are under appropriation, then the funds can be withdrawn.

Funds are necessary for the continuance of the Board; there are definite overhead expenses that must be met. Primarily our Board is a board to enforce the act that you gentlemen set up. We will revise it from time to time in order to take care of licensed men, and at the same time to stop unlicensed people from functioning. In spite of that act—there are over four hundred unlicensed chiropractors in the state.

We have stated from time to time that the Board has no knowledge of the number of men practicing in the state other than that on our register. When given a license, their address then is our only information available; we have no means of checking up. In reply to Dr. Shipps' comment, we have asked each and every Secretary in each and every county to cooperate with the Board in reporting illegal practitioners, because about one-third of the professionally licensed men in this state are not members of organized medicine.

If you deny us the right to have annual registration, it is going to imply that organized medicine is in complete harmony with that group of individuals who are and always have been opposed to the Medical Practice Act. They are attempting to destroy it all the time and the standards which it

represents and which you set up. It also further implies actually giving a stamp of approval to illegal practice in our state, and literally begs such groups to go as far as they like, in spite of the fact of the years of effort we have taken to build up high standards of criteria which our state has been justly proud to obtain.

I think that is all, Mr. President.

PRESIDENT LEWIS: I don't believe that quite answers the question.

I have studied this matter. May I crystallize the financial end of it in a few words?

There are two sources of income: Receipts from those taking examinations; receipts from those who apply for transfer or reciprocity from other states. The money received from *examinations* does not pay the expenses of the Board. The expenses of the Board have been supported largely in the past as a result of a hundred-dollar fee collected for *reciprocity*. Since December 7 reciprocity has practically dropped out of the field owing to the present emergency, so that at the present time there are no funds available.

Now, these funds are used in two ways: First, for the examination. According to your law, each examiner shall be paid \$500 a year for conducting two examinations. The Secretary of the Board receives from \$3000 a year up and spends practically half of each week at this job. The way the money is spent is in running the examinations, and in the prosecution of cases.

When the individual accused is found guilty and fined, part of that money is turned over to the State Board of Medical Examiners, but on the average the receipts represent one-half of the cost of the prosecution.

Does that answer your question, Dr. Bien?

DR. BIEN: You answered my question, but I should like to debate it.

I think that this bill that has been presented to the Senate within the past year, whereby they want to absolutely take all the funds from the Board of Medical Examiners and put it in the treasury, which they advocated—I think that is what is going to happen if we raise funds too much.

PRESIDENT LEWIS: Doctor, it is not my purpose or my function to discuss this bill. I again ask the question: Did I make clear the use of the funds? That was your question.

DR. BIEN: That is true.

DR. HENRY C. BARKHORN: Essex County is unalterably opposed to annual registration, even as a temporary expedient, because a right once surrendered is rarely regained, and if we put this bill

through temporarily, it may well be renewed for one reason or another over and over again.

We now have the right to practice medicine, unless we lose that right by committing an offense, which offense is clearly defined in our present State Medical Practice Act. We are now legal practitioners for life. Should this law go through, we will be legal practitioners only from one registration year to the next, with a ninety-day period of grace, and should, for instance, we return from the service on the ninetieth day, and on the ninety-first day do a minor operation, some shrewd lawyer in court would say, "Doctor, were you a legal practitioner in New Jersey on that day?" and you would say, "No, my license was in abeyance."

This applies also to a prolonged vacation, returning on the ninetieth day and doing something on the ninety-first. It applies to a prolonged illness. It applies even to our own carelessness. I venture to say a fair proportion of you have been caught on the Harrison Act and have been fined only twenty-five cents, but the law here says "Twenty-five dollars", and the Board of Medical Examiners must enforce the law. They have no choice. If you practice on the ninety-first day, you are guilty, and it is their duty to enforce this law.

There are other things, of course. It is a petty nuisance. There is a minor fee connected with it, and this fee must either be paid in cash, by certified check, or by post office money order. It is a nuisance problem.

Many county lists are complete. The smaller ones are all complete. The larger ones could be completed, and this money must be found, as must the other money, eventually. The Princeton Survey and the new state constitution will go through, and there will be no more segregated funds. That is the big feature in both of them, but we will still be saddled with annual registration run by the state instead of by the State Board of Medical Examiners, and there is no reason why they can't raise this charge to any indefinite sum.

I have carefully kept personalities out of my discussion. This Board has known for a material length of time that this was coming, but they have not economized within themselves. They are still paying \$3500 to the Secretary, with an honorarium which in the past has amounted to an additional thousand—there is \$4500. There is another \$4500 for the nine members, or \$5500 if there are eleven, and I think there are eleven.

There is the salary of a clerk, the salary of a stenographer or office manager. There is the salary per diem for these investigators.

We have confidence in our State Board. They are our friends. They represent us in a measure, although they have recently claimed that they are a sovereign body. But we have confidence in them. We know that they have withstood tremendous pressure in the past and, of course, they will surely also withstand tremendous pressure in the future and not succumb. They are honorable men.

You realize that on the ninety-first day your malpractice insurance is no longer good. If, because a shrewd lawyer proves you were not a legal practitioner, the verdict is against you, and it may cost a



lot of money. The responsibility for one such verdict would be a dreadful thing for us, the elected Delegates of The Medical Society of New Jersey, to assume.

DR. SPENCER T. SNEDECOR: I rise to a point of order. What subject are we discussing? Is there a motion before the House?

PRESIDENT LEWIS: There is a motion before the House.

DR. SNEDECOR: May I hear the motion?

DR. BURKETT: I made the motion before the House, that we adopt this resolution.

This resolution caused a great deal of discussion both by the opponents and proponents, who at the Committee hearing seemed to be about equally divided. The Committee feels that this very important matter should be decided on the floor of the House of Delegates. In presenting our report, the Committee unanimously favors the adoption of this resolution, with the proviso that the present Assembly bill be amended, for a period covering the present national emergency, but not to exceed a period of three years.

The resolution: "*Resolved*, That the Atlantic County Medical Society recommend to the House of Delegates adoption of and passage of legislation for annual registration."

I move that adoption.

PRESIDENT LEWIS: That was moved and seconded.

DR. W. A. TANSEY: I believe I am among the first, if not the very first, that had this annual registration come up. As a matter of fact, I was having a fight with the chiropractors in 1923.

At that time Olin West wrote to me from Illinois and he said: "I see that the annual registration is coming up. It came up in Illinois and we beat it down. It is coming up before your Society. I hope to God you beat it down."

He said it was a political affair—a bad law.

So far as the revenue is concerned for battling illegal practitioners, unlicensed practitioners, and so forth, that is a public affair. That has to be taken up by the Attorney-General of the State and fought out by him. Consequently if the doctors took it on their shoulders, they were going into a battle that belongs to the Attorney-General.

At the time it was brought up in the House of Delegates, nineteen years ago, the motion was defeated.

For a few years it lay dormant and then came back, crept back, and back, and back. So it happened a few years ago we had a fellow from New York State come over, and he tried to put it over in New Jersey.

I remember the time when Dr. McAllister was on the Board there and I had a conference with him, and he said, "Prosecution is the Attorney-General's business. It isn't our business at all." He said, "We are messing into it, and it is still the

Attorney-General's business to go over these affairs, no matter how we say they are ours."

We are all ready and willing to conform to rules. We have a medical license, a license to last forever, you might say. We have the different licenses we have to get, and, as Dr. Ill one time so well said, we have so many to get, even including a dog license.

At this time you say it is a war measure, but it will go on and on and nobody will stop it.

They give you the story that it is for the welfare of the public. We are ready and willing to protect the public. The public doesn't care so much about the doctors' end of it, but there is no reason at all why we should take this unnecessary burden that is going to react on us as a boomerang.

We have a legacy to hand down to the men and women who come after us in our profession, of which up to now we are mighty proud. We must not let them down by allowing such foolish and ridiculous laws to be passed, even though there may be many bad laws on the books—let not this be one of them.

DR. ULMER: Mr. President and Members of the House of Delegates: I am much impressed by the two negative presentations we have just heard. I particularly admire Dr. Barkhorn's scholarly one; however, I am not completely persuaded by it.

Someone once said that a doctor's worst enemy is himself, and I feel that this is particularly true in regard to this matter of annual registration. For a long time the medical profession has cried out, "We want our boys to control their own functions, their own boards. We want them to be self-administrative," and this is exactly what our present Board is, self-administrative. It is not harassed by political domination.

Some of you would compel the State Board to seek its funds elsewhere. Some of you would oblige the Board to accept state appropriations. Then immediately medical control is changed perhaps to political control.

For the sake of \$3.00 per year, the cost of annual registration—yes, for the sake of less than a cent a day—some of you would surrender one of our last remaining bastions, and, Mr. President and Members of this House of Delegates, annual registration can't be such an evil plan. Four professional groups in this state already have it, and up until the moment of this meeting they have not rebelled against it. Surely in these four groups there are self-thinking, self-asserting individuals.

Twenty states in the United States have it, and numbered in this group are the great states of New York and Pennsylvania. Certainly in these two large states there must be great numbers of self-thinking, self-assertive minds.

I am proud to state that in the minutes of our Gloucester County Medical Society is recorded the approval of annual registration.

DR. DAVID A. KRAKER: This problem of annual registration is historic in this Society. It is not new. It is rather peculiar that the war situation should bring the problem before us again upon the basis that the income has been cut as a result of the war.

It is stated by the Secretary of the Board that the primary purpose of this Board is enforcement. It isn't at all. The primary purpose is examination and qualification of physicians. The practice of the Board acting as prosecutor has been definitely an unsuccessful one since it was first established through the efforts of the Board. It is some years ago.

For many years in the experience of Essex County and my own personal experience in the prosecution of illegal practitioners in Essex County, in the days when we handled them through the office of the Prosecutor, we were eminently successful in ridding the county of the majority of men who were there practicing illegally.

In the primary analysis it is not in accordance with our ordinary constitutional methods to have funds that belong definitely to the state in the beginning, go into the hands of gentlemen who constitute a board, for their own purposes and for their own distribution.

Now, then, the question of the immediate need: The cut of income, as was said by the Secretary, is based primarily upon the loss of reciprocity fees, which is quite large. The men who now graduate are drawn into the service, very properly so. Very few of them are applying for licenses.

Charity begins at home. If the income isn't sufficient to cover, let the gentlemen, for the period of the war, just waive their incomes.

DR. SNEDECOR: I have had a good deal of interest in this subject for a long time. I was put on the Reference Committee, and I tried to have an open mind, but at the conclusion of the discussion it became more evident to me than ever that this question of annual registration had stirred up many larger issues which concern the Board of Medical Examiners.

This subject was brought to us primarily because they are short of funds.

On the constructive side of it, they do need some funds. Have they exhausted every means of obtaining funds? I don't think any of us would object to contributing voluntarily or through our State Society if some means can be found of tiding them through the present emergency for funds. It has not been shown convincingly to me that there is no other way of obtaining funds than through annual registration.

In the same way it has not been shown convincingly to me that annual registration is the answer to all of the needs of the Board of Medical Examiners. It hasn't been shown to me—and I raised the question before the Welfare Committee when this was first brought up—that the experience of other states has been so successful under annual registration that we should have it. I raised that question and asked the Board of Medical Examiners to answer it at our Welfare Committee meeting, and so far it hasn't been answered to my satisfaction.

DR. NORTON: Mr. President and Members of the House of Delegates: I am instructed by the Hudson County Medical Society to make an appearance here this morning and protest against annual registration in principle.

I wish we had the Chairman of the Reference Committee here, Dr. Marcus Newcomb, from Burlington, whom you know, and who as an Assemblyman from Burlington County, has had a tremendous amount of legislative experience. He concurred in the unanimous opinion of his Reference Committee. He said Annual Registration was not good from any standpoint; from the standpoint of legislation, the medical profession, economics, or of anything else.

I offer that observation. Dr. Newcomb has some competency.

I should like to go back to the opening sentence of Dr. Barkhorn when he said, "It is a surrender of a right that we now have, and I don't think we should surrender it."

I have that right, and you have that right; and if we continue forever and every day to surrender every right we have to governmental authority and boards, then we are going to be nothing at all.

It is said that New York now has annual registration. We are down here to discuss whether or not we should find another way of raising funds for the State Board of Medical Examiners. We are not here to consider, so they say, whether or not annual registration is a good thing. They need money to carry on the examinations and all their various activity; and how will they get it? They will get it from dedicated funds. What does that mean? It means the money they get, from annual registration, licensure, or reciprocity, or fines will all be put in a pot over which they have control.

They allocate that money to pay a Secretary, to pay each one of their examiners for what they do, and to pay their investigators.

Dr. Kraker asks: What do you do if your income falls below your overhead? You cut the overhead. Up to now the income of the State Board of Medical Examiners was pretty good. I find no fault with them for getting it, but I don't see why we should sacrifice our right—and I reemphasize with all the sincerity of which I am capable, we are sacrificing an inherent right, a real right, a great privilege. What is going to happen to the State Board of Medical Examiners if they don't have the annual registration? Their personnel is the same, appointed in the same manner as all along.

PRESIDENT LEWIS: Well, gentlemen, if anybody has anything new—we have had discussion by orchestration, by chamber music, by organ, and by jazz. (Laughter.)

I have promised Dr. Cosgrove the floor. Please make it brief, Dr. Cosgrove.

DR. COSGROVE: Mr. President and Members: I hesitate after the most effective and oratorical efforts you have heard from a number of men, to interpolate anything else, but the Secretary of the State Board of Medical Examiners said, "*This is your law, the Medical Practice Act is the doctors' law; therefore you ought to support it by your contributions.*" Now, that is *not so*. If the Medical Practice Act is merely the doctors' law, is merely a labor union measure to protect the doctor, then

I don't propose, if I can help it, to sacrifice my potential license to follow my life work for the sake of such a law, nor even to pay the \$2.00 or \$3.00 that it will cost me.

The Medical Practice Act is the act of the *people* of the State of New Jersey, through its Legislature, for the benefit of all the people. That is what we told them when we went before them and asked them to pass it. Of course, we are more deeply cognizant of its need than the average citizen is. We are more interested in it than the average person is, or even the average legislator, but it is a public health act for the protection of the people of New Jersey, and the funds for its operation should come from the people of New Jersey through its legislature and not through us.

The second implication that has been offered here, that I think is also implied largely by Dr. Ulmer, if we make the State Board of Medical Examiners independent by giving them full control over its funds, everything will be rosy—he forgets altogether the tendency, as pointed out by Dr. Barkhorn and others, for aggrandizement of every bureaucracy when it is independent of the State Medical Society, of the legislature, and of any other control but the control of its own funds.

He implies that if the funds for the State Board of Medical Examiners come through the channels of legislative appropriation, under which most other State Boards function efficiently enough, there will be political pressures laid on that Board which will not exist under the independent set-up of that Board. That is nonsense.

Dr. Norton and others have pointed out that all of these appointments are made by the Governor. We exercise a little recommendatory control over a minority of the Board only, but I have served on an appointive State Board and if you think that the mere matter of the appropriation's being dependent upon the Legislature or not is going to make any difference in the enormity of pressure that may be brought on individual members of any Board, you simply don't know what you are talking about, and so I move, sir, the question.

DR. ROYAL A. SCHAAF: Mr. President and Members of the House of Delegates: I don't want to debate the merits or demerits of annual registration. All the members who have spoken against it are my close personal friends, and I have no personal feelings about some of the remarks made about the Board.

I should like to correct two impressions, two of them—one is that the inspection of the Los Angeles School was made by someone incompetent to do it. It was made by Dr. Barbash, an esteemed member of the Society, one of the members endorsed by the State Society.

The other relates to Dr. Hallinger. He gets \$4500 a year. He earns every nickel of it. (Applause.)

DR. NORTON: May I correct the statement of mine, then?

PRESIDENT LEWIS: Yes, sir, briefly.

DR. NORTON: When the question came before the Board of Trustees about the inspection at Los Angeles, I was told that the inspection of the Los Angeles School was made by a member of the Board of Medical Examiners who does not come before us for approval. It was not Dr. Barbash, and if I have in any way done anything to embarrass Dr. Barbash by my misstatement, I now want definitely and publicly to make this retraction.

PRESIDENT LEWIS: Dr. Barbash wishes to speak.

DR. BARBASH: Gentlemen, Dr. Schaaf and Dr. Norton are both right. Dr. Liva made an inspection of the school three years before I did. Last year I spent three days in Los Angeles at the School of Osteopathy. I inspected their charts and spent two full days besides, and I was told they had been inspected before. I felt it was among a good many of our Class A schools and the Los Angeles School of Osteopathy was approved by the Board of Medical Examiners, and it was because I personally felt that it was their just due that they be so rated.

Now, the Philadelphia School of Osteopathy, I think, was inspected and approved before I came on the Board, and I don't know anything about that.

There are some things about the Board of Examiners which in my opinion need correction, and so far as I am concerned, I will do my best to see that they are corrected. Some of the criticisms, I think, are just.

The only way we find cases that need prosecution is when they are called to our attention, and you naturally will see that we can't cover the entire ground, and, so far as I am concerned, if they take prosecutions away from us and make us a Board of Examiners instead of prosecutors, I shall be tickled to death.

PRESIDENT LEWIS: Are you ready for the question?

The question was called for.

PRESIDENT LEWIS: *You are now voting on the question of the adoption of a resolution supporting passage of a bill which calls for annual registration, which it is recommended shall be revised to provide that this registration shall last for the duration of the war or not beyond three years.*

The motion was put to a vote and *was lost*.

DR. BURKETT: I should like to move the adoption of this report, deleting Resolution No. 2 on annual registration.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. HILTON S. READ: You have tabled a motion from Reference Committee "D", which disapproved of this and that should be lifted from the table.



PRESIDENT LEWIS: We will proceed to act upon the tabled recommendation from Reference Committee "D" which disapproved of Annual Registration of Physicians.

DR. SNEDECOR: I move the adoption of that part of Reference "D" report which covered disapproval of annual registration and the suggestion that the Board of Trustees discuss problems and further develop better contact between the Board of Medical Examiners and the State and County Societies.

The motion was regularly seconded, was put to a vote, and *was carried*.

## REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

DR. SAMUEL ALEXANDER:

### Report of Reference Committee on Constitution and By-Laws

The Reference Committee on Constitution and By-Laws approve the following changes to our By-Laws:

#### CHAPTER VIII

Sec. 2: After "Committee on Finance", introduce "Committee on Scientific Work".

After Sec. 5, insert "*Section 6—Committee on Scientific Work*".

"The Committee on Scientific Work shall consist of one member from each councilor district to be chosen by the House of Delegates, and two members appointed by the President. Those who are to be elected are as follows:

"At the first election one (1) member shall be elected for a period of one (1) year; one (1) member for a period of two (2) years; one (1) member for a period of three (3) years; one (1) member for a period of four (4) years; and one (1) member for a period of five (5) years; and as the terms of these members expire, new elections shall be for periods of five (5) years each.

"The members who are to be appointed by the President shall be appointed as follows:

"The first appointment shall be for a period of one (1) year; and the second appointment for a period of two (2) years; and as the terms of these members expire; new appointments shall be for periods of two (2) years.

"It shall choose its own chairman and secretary.

"The duties and functions of this committee shall be:

"a. To collect information, through the county reporters or otherwise, of members who are interested in prosecuting scientific studies or research, privately or in hospitals, schools, health departments, or other agencies in the state;

"b. To support and encourage such work, as means and opportunity may be available, and in general to promote interest in original scientific work among the members of the Society;

"c. To facilitate contacts and exchanges between workers in related fields in different parts of the State;

"d. To facilitate the presentation of such work and its results to the Society, either at its meetings, through the committees in charge, or in the *Journal*, through the Publication Committee."

Renumber the remaining sections of Chapter VIII, by adding one to each number.

The Committee did not approve of the following proposals because it feels that the provisions of the present By-Laws take care of these proposals:

#### CHAPTER VIII

##### Amend *Section 6*

By renumbering it as Section 7.

By changing the period after "five members" at the end of the first sentence into a comma, and adding: "with the president and secretary *ex-officio*".

By striking out all after the first paragraph, and substituting therefor the following: "The committee may arrange itself into such subcommittees as it deems most conducive to the efficient performance of its functions. It shall have entire charge of the program and all arrangements for the sessions, scientific and technical exhibits, and other features of the annual meeting and associated functions, subject to the directing control of the House of Delegates, and of the Board of Trustees, to which it shall report its plans, for approval. But in planning the scientific features of the meetings, preference shall be given to the work of the members of this Society, and special prior preference to the recommendations of the Committee on Scientific Work. Free discussion of all presentations shall be reasonably encouraged."

#### CHAPTER X

##### Amend *Section 2*, by adding:

"Each county society shall cause its secretary to transmit to the office of this Society, as promptly as may be, an abstract of the proceedings or minutes of each regular or special meeting."

Strike out *Section 7*, and substitute the following:

*Section 7—Reporters.* Each county society shall choose a reporter, whose duty shall be to collect information on epidemics or other public health matters, hospital news of general interest, reports of research or scientific studies by members, unusual clinical cases, and similar items, and to report them to the committees on Publication and on Scientific Work of The Medical Society of New Jersey. And these committees shall report jointly to the House of Delegates each year the names of reporters who have done meritorious work, proportionate to their respective opportunities.

DR. ALEXANDER: These changes have been submitted by Dr. Marsh.

PRESIDENT LEWIS: What is your recommendation?

DR. ALEXANDER: First that we approve a new standing committee on scientific work, and that the other proposals submitted are adequately taken care of in the present by-laws

and therefore, in our opinion, not essential at the moment.

I move the adoption of the report.

The motion was regularly seconded.

PRESIDENT LEWIS: Is there any discussion? The question was called for.

PRESIDENT LEWIS: All in favor indicate by saying "aye"; opposed, "no". The ayes have the majority and *it is so ordered*, and the Reference Committee's report is approved.

SECRETARY STAHL: I don't think there are fifty members here.

I move that this be considered the first reading of the proposed change in By-Laws and be tabled until next year.

PRESIDENT LEWIS: Do I hear a second to that motion?

The motion was regularly seconded.

PRESIDENT LEWIS: The motion is that this be considered the first reading and the matter be acted upon at the next meeting of the House of Delegates.

DR. MARSH: There will not be another till next year. The motion as amended can be passed now. An amendment to the By-Laws can be made and passed at one session.

SECRETARY STAHL: It must be laid over one day, though.

PRESIDENT LEWIS: It has fulfilled all the requirements of the By-Laws. It has been read twice in open meeting and the day has intervened, and it has been handed over to the Reference Committee on Constitution and By-Laws. *The motion calls for postponement and delay. That motion is now on the floor.* If you wish to pass this amendment as recommended by your incoming President, in order that he may operate it for the next year, you will need first to defeat this motion.

The meeting opened with an attendance of fifty members and I think it quite legal to act.

DR. ALEXANDER: You are absolutely right. We do not have to have fifty members at the moment.

SECRETARY STAHL: I don't believe that.

DR. ALEXANDER: This program submitted by Dr. Marsh and approved by the Committee on Constitution and By-Laws, provides for a Scientific Committee to function primarily in the interim between the annual meetings. It does not interfere in any way with the present set-up of the Program Committee. That part pertaining to the Program Committee, submitted by Dr. Marsh, we did not approve because we felt it was already covered by the present By-Laws.

SECRETARY STAHL: Now, I am heartily in favor of passing this. There is only one thing, there is a bad precedent set—a certain amend-

ment to the By-Laws was read at the first session of the House of Delegates; then it goes to the Reference Committee, who make certain changes. Legally, I think that as soon as a change is made, another reading would have to be made. Somebody might amend an amendment so that it would be entirely different from what was originally intended; however, as far as I am concerned, I think this amendment is all right and should be passed.

DR. GRAY: I think that every feature should be waived that possibly can be waived, to help Dr. Marsh work out any thoughts, and if you wait for next fall for a meeting of the delegates, that is considerable time.

PRESIDENT LEWIS: The ruling of the Chair is that this is a second reading, that there has been an intervening day. It has been referred to the Reference Committee, and this body may now act. The motion on the floor is that this shall be deferred for action until the first meeting of the House of Delegates at the next annual meeting.

We approved the report. We have not voted on the passing of an amendment to the By-Laws.

DR. BURRITT: I believe I am in order. The motion to table the motion is now before the House. I will second it. Instead of making it negative, therefore you make it positive.

PRESIDENT LEWIS: It is moved to table the motion that is before the House.

It is not debatable. Was there a second?

MEMBER: Yes.

PRESIDENT LEWIS: All in favor indicate by saying "aye"; all opposed, "no". I will ask for a rising vote. Those in favor of tabling this motion, rise; those opposed to this motion, rise. The motion *is lost*.

We are now back to Dr. Stahl's original motion that action upon this amendment be deferred until the next meeting of the House of Delegates one year from now—and a couple of months.

The motion was put to a vote and *was lost*.

PRESIDENT LEWIS: Now, what is your pleasure as to the disposition of this amendment?

DR. KRAKER: This resolution was read as first reading of amendment to the By-Laws?

PRESIDENT LEWIS: No, sir, second reading. It was presented by Dr. Marsh at the first meeting of the House of Delegates. It has been before the Reference Committee on Constitution and By-Laws. It is now perfectly legal for it to come up for passage. What is your wish as to disposition of this?

DR. HOLLINGSWORTH: I move the adoption of it.

The motion was regularly seconded, was put to a vote, and *was carried with one dissenting vote*.

SECRETARY STAHIL: And I should like to be so recorded.

PRESIDENT LEWIS: Record the one "nay".

#### REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

PRESIDENT LEWIS: I will now call for a report of the Reference Committee on Miscellaneous Business, Dr. Ulmer.

DR. ULMER:

1. *Supplemental Report of Subcommittee on Legislation.* (See page 9.) We have reviewed this report and approve it.

I move acceptance of this portion of the report.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. ULMER:

2. *"This Is the House That Jack Built"*—a voluminous report submitted by Dr. Norman W. Burritt. This report with its rather weird and unsatisfactory title we did not completely review because of its length and our insufficient time. However, we are informed that this report is now being studied by a special committee of the Board of Trustees and we would recommend that it be left with this committee for continued study and report.

I move, sir, that part of our report be adopted.

DR. BURRITT: In discussing the motion for adoption of this report, may I ask Dr. Costello if that special committee has not already fulfilled its function and made its report, and that the report of that committee, as a part of the report of the Board of Trustees has already been adopted by the House of Delegates, or is that special committee to continue in the future?

DR. COSTELLO: The report as I read it this morning was that the committee up to date had not had time to digest this in detail to justify any other further action at the present moment.

PRESIDENT LEWIS: That committee is still in existence and is ready to consider this matter further, make further study, but they didn't feel from the time they have had to give study to it, that it justified any further action at this time.

The motion was regularly seconded, the question was called for, and the motion was put to a vote and *was carried*.

DR. ULMER:

3. *The recommendation of the Committee on Honorary Membership* (see page 15) that Dr. Josephine Baker, retired, of Princeton be elected an honorary member, is approved.

I move, sir, that this part 3 of our report be approved.

The motion was regularly seconded, was put to a vote, and *was carried*.

DR. MARSH: Does that involve an election or does that have to be taken up separately?

PRESIDENT LEWIS: No, that is election. It approves the election.

DR. ULMER:

4. *The Report of the Advisory Committee to the Woman's Auxiliary.* (See page 192, April Journal.) We have reviewed this report and recommend its adoption. We would commend the Chairman, Dr. William E. Dodd, for his conscientious and sympathetic interest in the Auxiliary.

In order to stimulate attendance and interest at County Auxiliary meetings, we would recommend that the president and committee chairman attend the Annual Auxiliary Meeting and also the Board Meetings. By doing so they will get the inspiration of constructive programs and can transmit these definite objectives to their County Auxiliaries.

I move that this part 4 of our report be adopted.

The motion was regularly seconded, was put to a vote, and *was carried*.

PRESIDENT LEWIS: That request was complied with during the past year, Doctor.

DR. ULMER:

5. *The Place and Date of the 1943 Annual Meeting.* Everything is, of course, most uncertain for the next year. However, we would recommend that the 1943 Annual Meeting be held in Atlantic City in the last week of May.

I move that part 5 of our report be adopted.

DR. ALLMAN: Atlantic County would like to second that motion and to welcome you here to the south part of New Jersey.

DR. WALKER: I heartily concur in that, but in the event of emergency making Atlantic City impractical, is there any machinery in the Society giving the Trustees or some other body power to change that?

PRESIDENT LEWIS: It is within the power of the Board of Trustees to change that if necessary.

The motion was put to a vote and *was carried*.

DR. ULMER: This complete report is respectfully submitted by the Committee, and we move adoption of the report as a whole.

The motion was regularly seconded, was put to a vote and *was carried*.



### CHIROPODY

DR. QUIGLEY: I would ask unanimous consent to introduce a motion. It is rather important. Dr. Barbash called my attention to it. Perhaps I might speak of it before asking the House to grant the privilege of introducing it.

Dr. Barbash suggested some time ago the thought of our Delegates to the A. M. A. representing to the Council on Hospitals and Medical Education that they take under consideration the advisability of attempting to regulate by definition and by defining the scope and limitations of chiropody. Preparatory to, and in the course of attempting to get up a definition, we had considerable correspondence with the A. M. A., and found that the previous Secretary on the Council on Hospitals and Medical Education apparently had this thought in mind and had made some attempt, and the present Director, I think, also favors the idea.

There is now a great diversity of definition and scope, and when a state attempts to do this sort of thing, there is absolutely nothing to go by. I should like to move that our Delegates recommend to the Council on Hospitals and Medical Education the advisability of the Council taking over the inspection of chiropody schools and attempt to establish a basic definition, and define the scope and limitations of practice that can be made by this Council.

I ask that I be given unanimous consent to introduce that.

PRESIDENT LEWIS: Does the House grant Dr. Quigley unanimous consent to do so?

DR. ALLMAN: I so move.

The motion was regularly seconded, was put to a vote and *was carried unanimously*.

PRESIDENT LEWIS: Dr. Quigley, proceed.

DR. QUIGLEY: I move that the Delegates be instructed to present to the House of Delegates of the A. M. A. the action that I have just proposed.

DR. WOOD: I second the motion.

The motion was put to a vote and *was carried*.

DR. MARSH: Mr. President, I should like to ask unanimous consent to introduce a resolution. A good many of you present know that our revered senior Fellow of this Society and Honorary Member, Dr. Edward J. Ill, has been sick and is now, I am glad to hear, making favorable progress toward recovery, and I should like to introduce a resolution that the Secretary of the Society be instructed to transmit to Dr. Ill an expression of our satisfaction at hearing of his recovery and our confidence and expectation of having him with us next year.

PRESIDENT LEWIS: I will entertain a motion granting Dr. Marsh the privilege to present this resolution.

DR. ULMER: I so move.

The motion was regularly seconded, was put to a vote, and *was carried unanimously*.

PRESIDENT LEWIS: Dr. Marsh, will you formally make your motion?

DR. MARSH: I move it as stated.

The motion was regularly seconded, was put to a vote, and *was carried*.

PRESIDENT LEWIS: Are there any other matters to come before the House?

If not, I wish to express my extreme gratification at the splendid attendance at this morning's session, and also for your loyal support during the past year, and at this time I want to introduce your new President, Dr. Elias J. Marsh.

(The assembly arose and applauded.)

PRESIDENT-ELECT MARSH: I repeat what I said last night. I hope I may make 50 per cent of Dr. Lewis' batting average during the coming year.

PRESIDENT LEWIS: A motion to adjourn is in order.

Upon motion regularly made and seconded, it was voted to adjourn. Thereupon the meeting adjourned at 12:50 p. m.

# WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

## I. PRE-CONVENTION BOARD MEETING

MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The Pre-convention Meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall on Tuesday, April 21, 1942, at the call of the President, Mrs. O. R. Carlander.

The minutes of the March meeting were approved as read.

The Treasurer, Mrs. T. P. McConaghy, submitted a statement showing a balance of \$770.89. The Treasurer's statement was filed.

The President submitted her report. (See page 38.)

Dr. Dodd brought greetings from The Medical Society of New Jersey and thanked us in their behalf and personally for the splendid help we have given them this year.

Committee Chairmen reported as follows:

**Bulletin:** Mrs. Carlander stated that our goal for this year was 100. We have procured 97 subscriptions to date.

**Entertainment:** Mrs. David B. Allman, Chairman, called attention to the events planned.

**Legislation:** Mrs. Max L. Weimann, Chairman, advised that she had received material from Dr. Pollack and Dr. Quigley, and that she is incorporating this information in her annual report.

**Finance:** Mrs. Chester I. Ulmer, Chairman, requested that outstanding bills be turned in today.

**Press and Publicity:** Mrs. Asher Yaguda, Chairman, reported that this meeting has been publicized.

**Printing:** Mrs. J. J. McGuire, Chairman, reported that she had distributed no stationery since the last meeting.

Mrs. Carlander announced that Mrs. Kinch, Chairman of Revisions, and Mrs. Pigott, Chairman of Credentials, were in Florida. Mrs. Lippincott will be acting Chairman of Revisions, and Mrs. Hornberger and two assistants will take care of credentials.

Miss Ashmun, Registered Nurse from the Orange Memorial Hospital, was presented at this time. Miss Ashmun represented the Nursing Defense Council and appealed to us as the professional group to help in the recruitment program.

Mrs. Carlander read a letter from Mrs. Crowe of Cape May County. After some discussion Mrs. Max L. Weimann moved that the matter be referred to our Advisory Board and the Advisory Committee (or Dr. Dodd) for solution. Seconded by Mrs. McDonald and carried.

### NEW BUSINESS

Mrs. Hornberger read a letter from the National advising her that she would represent the Auxiliary at the National Convention. This situation will be taken care of by the Revision which will come before the general session on Wednesday.

Mrs. Carlander read a letter from Dr. Davidson, Editor of *The Journal*.

The President appointed Mrs. G. E. McDonnell and Mrs. J. J. McGuire to serve as members of the Auditing Committee.

Mrs. A. Haines Lippincott announced the first convention dinner of the newly organized Fellowettes—the Past Presidents of the Woman's Auxiliary to The Medical Society of New Jersey.

There being no further business the meeting adjourned.

## II. THE FIFTEENTH ANNUAL MEETING

MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The Fifteenth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was called to order by the President, Mrs. O. R. Carlander.

The invocation was delivered by Rev. Har-

old Gaunt. Mrs. Morton Major, President of the Woman's Auxiliary to the Atlantic County Medical Society delivered an address of welcome, to which a response was made by Mrs. J. H. Hornberger, President-Elect.

A memorial service was conducted by Mrs. James A. Hunter for the following members:

Camden County:

Mrs. Joel Fithian of Camden

Mrs. Thomas B. Lee of Haddonfield

Gloucester County:

Mrs. Maude Groves of Woodbury  
(widow of Dr. Duncan Campbell)

Mrs. Allen Black of Clarksboro

Middlesex County:

Mrs. Joseph Mark of Woodbridge

Passaic County:

Mrs. George E. Tuers of Paterson

Warren County:

Mrs. Frank A. Wolf of Phillipsburg

The President announced that Mrs. A. Haines Lippincott would act as Parliamentarian. The Rules and Procedure of the Convention were read by Mrs. Lippincott, and it was regularly moved and carried that these rules be accepted.

The Corresponding Secretary read telegrams from Mrs. Jessurun and Mrs. Bickner stating that they would be unable to attend the meeting and expressing regrets.

The minutes of the last Annual Meeting were approved as read.

The President appointed Mrs. L. L. Glover timekeeper.

The Treasurer's report was read and approved. (See page 40.)

The Auditing Committee's report was read and approved.

Reports were submitted by the following Officers and Committee Chairmen:

Corresponding Secretary, Mrs. L. L. Glover

Recording Secretary, Mrs. Banks S. Baker

Treasurer, Mrs. T. P. McConaghy

Archives, Mrs. C. C. Chianese

Arrangements, Mrs. R. J. Ruvane

Arts, Hobby and Medical History, Mrs. Ily R. Bier

Bulletin, Mrs. S. H. Jessurun

Credentials, Mrs. A. W. Pigott

Finance, Mrs. Chester I. Ulmer

Mrs. Ulmer moved that in the future no receipted bill will be required for the Treasurer's Audit. Seconded and carried. Mrs. Ulmer explained further that no bills will be returned—the cancelled check will act as a receipt and the okeyed bill will be the Treasurer's record.

Historian, Mrs. James Hunter

Legislation, Mrs. Max L. Weimann

Organization, Mrs. A. E. Jaffin

Press and Publicity, Mrs. Asher Yaguda

Printing, Mrs. J. J. McGuire

Program, Mrs. A. Haines Lippincott

Public Relations, Mrs. Don A. Epler

Resolutions, Mrs. H. W. Hubbard

The Revisions Committee presented the following revision in the By-Laws:

#### CHAPTER I—Elections, Section 1-f—

New officers shall be installed at the Annual Meeting but they shall not take office until June 30.

Mrs. McDonald moved that this revision be referred back to the Fellowettes. Seconded and carried.

It was regularly moved, seconded and carried that these reports be accepted.

Reports were submitted by the following County Presidents:

Atlantic—Mrs. Morton Major

Bergen—Mrs. Howard M. Meyer

Burlington—Mrs. Edward H. Wyman

Camden—Mrs. George B. German

Essex—Mrs. Edward W. Sprague

Gloucester—Mrs. Paul M. Pegau

Hudson—Mrs. Andrew C. Ruoff

Mercer—Mrs. George N. J. Sommer

Middlesex—Mrs. Samuel Breslow

Ocean—Mrs. Emanuel M. Sichel

Somerset—Mrs. E. T. Flint

Union—Mrs. George Knauer

Warren—Mrs. Floyd Shimer

The reports of the County Presidents were accepted on motion.

The meeting recessed for luncheon.

The meeting reconvened at 3:20 p.m.

Mrs. Lippincott, Chairman of the Fellowettes, presented the following revision:

#### CHAPTER I, Section 1-f of the By-Laws.

New officers shall be installed at the Annual Meeting but they shall NOT take office until after the convention of the Woman's Auxiliary to the American Medical Association.

Mrs. Lippincott moved the adoption of this revision. Seconded and carried.

Mrs. McDonald moved that we pay the expenses—railroad fare plus six dollars a day for the business sessions—of the President and the President-Elect to the A. M. A. convention in Atlantic City. Seconded by Mrs. McDonnell and carried.

Mrs. Carlander advised that she had taken up the disbandment of Cape May County with the Advisory Board and the Advisory Committee. The President of the Cape May County Medical Society does not want this group to be dropped. Mrs. Glover moved that Cape May County be allowed to become an inactive auxiliary and pay national and state dues in order to belong to our state group. Seconded by Mrs. Ruoff. This motion was lost. Mrs. McConaghy moved that we collect national and state dues from the Cape May Auxiliary and permit their status to remain the same. Seconded by Mrs. Glover and carried.



The following members were elected to serve as members of the Nominating Committee:

Mrs. George A. Rogers  
Mrs. A. Haines Lippincott  
Mrs. David B. Allman  
Mrs. C. P. Segard

The following resolutions were adopted:

Resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey here assembled hereby express thanks to Mrs. David B. Allman and her committee for their work in so carefully providing for our comfort and entertainment during this our Annual Meeting.

Resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey here assembled hereby express our thanks to Mrs. Oswald R. Carlander, our President, her officers and chairmen for their work on behalf of the Auxiliary during this past year.

Resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey hereby express our thanks to the management and staff of Haddon Hall for their coöperation in so carefully providing for our comfort and welfare during our Annual Convention.

Resolved, that the Secretary send a letter of sympathy to the members of the families of our members who have left us this year for that spiritual life beyond the grave.

Resolved, that these resolutions be spread upon our minutes and a copy of each resolution be sent to those mentioned in them respectively.

Mrs. R. J. McDonald, Chairman of the Nominating Committee, submitted the following names for election:

President-Elect: Mrs. Asher Yaguda, Newark  
First Vice-President: Mrs. James H. Mason, Atlantic City  
Second Vice-President: Mrs. James J. McGuire, Trenton  
Recording Secretary: Mrs. Banks S. Baker, Camden  
Treasurer: Mrs. Thomas P. McConaghy, Camden  
Directors: Mrs. Chris P. Segard, Leonia  
Mrs. William C. Meineke, Roselle

There being no other nominations the candidates were declared duly elected.

The newly elected officers were installed.

Mrs. A. Haines Lippincott spoke on Cancer Control.

Mrs. James H. Mason reported that a total of 149 members had registered at the Auxiliary desk, and 179 at the State Society registration desk.

There being no further business the meeting was adjourned.

### III. PRESIDENT'S ANNUAL REPORT

MRS. OSWALD R. CARLANDER, Merchantville, N. J.

New Jersey looks back over a year of steady growth and real accomplishment. Our membership has increased beyond the 1,000 mark with auxiliaries organized in fifteen counties throughout the state. Eight of this number were represented at the National meeting in Cleveland in May, 1942, with a total of thirteen delegates.

The important starting point of the year was a conference with Dr. Thomas K. Lewis, Dr. William E. Dodd, and Dr. LeRoy A. Wilkes to determine the subjects for emphasis among our auxiliaries for the year. They included:

1. Medical Preparedness.
2. Common Sense in Nutrition.
3. The Medical Service Administration.
4. The American Way of Practicing Medicine.
5. The Hospital and Your Community.

Early in the fall the Medical Preparedness part of our program was under way. Guided by the Advisory Committee and the President of The Medical Society of New Jersey, our membership was surveyed for the purpose of determining who would be able and willing to staff emergency hospitals in case of a disaster. The results were tabulated and given to the office of Civilian Defense in each community. Because of the interest stimulated by

this questionnaire, many of our members are now concentrating upon first aid, nurses' aides, and refresher courses in nursing, dietetics, secretarial and technical training, in order to be ready to serve in any emergency. One county has already organized an emergency hospital unit, and another has also offered its services to hospitals within its community.

To further interest in the subjects listed for our consideration, our Program Chairman developed the idea of informing our membership through presenting outstanding speakers in each field at our four open State Board meetings. Likewise our Public Relations Chairman incorporated these ideas presented to us by the Medical Society, in her program planned to assist each County Auxiliary.

The results of our year's efforts are encouraging. Every Auxiliary has participated in some way in promoting the State program through public health forums, moving pictures to visualize health education, reciprocity teas, or attendance at State Board meetings to hear authorities. The placing of physicians as speakers before lay groups, health institutes stressing nutrition particularly, essay contests in schools on various health subjects, and the promotion of the "Doctors at Work Broadcast",

sponsored by the A. M. A., have all contributed to the success of this program.

It is well to mention here that our Publicity Chairman has been unusually successful in bringing before the public our activities with the thought of making people more health conscious. An average of four pages monthly appeared in *The Journal*. Over 400 articles were published in lay newspapers.

Another achievement of which our Auxiliary can be justly proud, in these times especially, includes the support of four Student Loans and Scholarships for those desiring to enter the nursing profession. Union, Atlantic, Mercer, and Burlington raise funds for these every year.

Other highlights in our program include a useful "legislative quiz", prepared by our Legislative Chairman, that will be of permanent value to our Auxiliary; a creditable history of the Auxiliary, and a number of subscriptions to the Bulletin.

In addition to carrying forward these educational programs, the majority of our members have done extensive work in Red Cross. One auxiliary bought wool and knitted regulation garments for soldiers in two army camps within our areas. Another enrolled a number of its members in motor mechanic courses. Other counties made substantial money contributions to the Red Cross, and many individual members were active in soliciting funds for this cause.

Like all other patriotic citizens, our women have coöperated in buying defense bonds and stamps. The largest purchase, a \$1,000 defense bond, has been made by Hudson County. Reported also among our war efforts is the splendid service that the Burlington County members render at the Fort Dix Service Center. Two days a month busy doctors' wives find time to be hostesses to as many as four thousand soldiers. Mercer County has offered fine hospitality to soldiers on various occasions.

Generous local support has been given to many worthwhile health-minded groups. Donations of gifts and money have been presented to the Y. W. C. A., the Y. H. C. A., Girl Scouts, "Kiddie Keep We'll Camps", children's homes, tuberculosis societies and hospitals. City dispensaries and blood banks have shared in the funds raised by two auxiliaries. To date five field unit sets for use in an emergency have been purchased as a result of a suggestion from the Medical Preparedness Committee based upon a request from the Medical and Surgical Relief Committee of America.

Another outstanding philanthropy, which represents sustained effort over a period of years to raise funds for a worthy cause, is our Society for Widows and Orphans.

The final activity of the year will be our privilege of acting as hostess to approximately 1,500 women coming to Atlantic City to the meeting of the National Auxiliary from June 8th to June 12th. Mrs. David B. Allman already has her plans completed, and Mrs. Ily R. Bier, National Chairman of Exhibits, is working diligently to present the work of our auxiliaries in an interesting fashion to bolster morale.

This is the state picture as I have seen it from visiting thirteen auxiliaries and from reading reports of the accomplishments of all. Member participation in these many activities has in itself promoted friendship among physicians' families, for which we were founded. This, together with your many achievements, which space permits me to mention only in part, are evidences that you have fulfilled well your obligations as members of this Auxiliary. For your loyal coöperation, your friendship, and for the valuable assistance from the President and the Advisory Committee of The Medical Society of New Jersey in developing the year's program, I shall be always grateful.

#### IV. POST-CONVENTION BOARD MEETING

MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The post-convention meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held in the Solarium of Haddon Hall on Thursday, April 23, 1942.

The meeting was called to order by the President, Mrs. J. Howard Hornberger.

The minutes of the pre-convention meeting were approved as read.

The Treasurer, Mrs. T. P. McConaghy, submitted a statement which was filed.

The President announced the Committee Chairmen for the coming year.

The President requested that the incoming County Presidents notify her as soon as they are installed and, if possible, send a list of officers and chairmen.

Mrs. Mason moved that the necessary sta-

tionery be printed for the coming year. Seconded and carried.

Mrs. Ulmer moved that all Board meetings be open meetings. Seconded and carried.

Mrs. McConaghy moved that we purchase one dozen new hand books. Seconded and carried.

Mrs. Hornberger announced that the October Board meeting will be at the Trenton Country Club.

The President urged that we all follow Mrs. Jessurun's suggestion and subscribe to the Bulletin, especially state officers and chairmen as well as key members in the counties.

The Credentials Committee reported a total of 182 registered with the state chairman and 234 with the state office registrars.

There being no further business the meeting adjourned.

## V. TREASURER'S REPORT

MRS. THOMAS P. MCCONAGHY, Treasurer, Camden, N. J.

	Emergency	General	Total
May 21, 1941, Balance on hand	\$125.58	\$ 615.09	\$ 740.67
RECEIPTS			
Sale of one handbook	\$ .40		
Dues	621.00		
	<u>\$621.40</u>	<u>62.10</u>	<u>559.30</u>
			<u>621.40</u>
	<u>\$187.68</u>	<u>\$1,174.39</u>	<u>\$1,362.07</u>
DISBURSEMENTS			
President (Mrs. McDonald) 1940-41	\$ 22.70		
Legislative Chairman (Mrs. Bickner)	8.52		
Credentials Chairman (Mrs. Hornberger) 1941-1942	2.50		
Expenses to National (Mrs. McDonald)	56.75		
Expenses to National (Mrs. Carlander)	53.00		
Printing (Mrs. McGuire)	29.56		
Expenses January and October meetings	4.40		
Expenses President (Mrs. Carlander)	107.95		
Expenses Corresponding Secretary (Mrs. Glover)	2.93		
Expenses Treasurer (Mrs. McConaghy)	9.00		
Expenses Historian (Mrs. Hunter)	1.50		
Expenses Finance Chairman (Mrs. Ulmer)	2.80		
Expenses Bulletin Chairman (Mrs. Jesserun)	5.00		
Expenses Nominating Committee Chairman (Mrs. Hornberger)	2.37		
Expenses Credential Chairman (Mrs. Pigott)	1.46		
Expenses Public Relations Chairman (Mrs. Epler)	3.48		
Expenses Program Chairman (Mrs. Lippincott)	8.30		
Expenses Widows and Orphans Chairman (Mrs. Miningham)	3.00		
Expenses Press and Publicity Chairman (Mrs. Yaguda)	6.10		
Past President's Pin	26.40		
National dues	251.00		
April 22nd luncheon (Mrs. Allman)	25.00		
	<u>\$633.72</u>	<u>633.72</u>	<u>633.72</u>
	<u>\$187.68</u>	<u>\$ 540.67</u>	<u>\$ 728.35</u>
Balance April 22, 1942—In Emergency Account			\$187.68
—In General Account			540.67
Total			<u>\$728.35</u>

## VI. ATTENDANCE

Following are the registration figures for the 1942 Annual Meeting:

Executive Board	4
Advisory Board	4
Directors	4
Chairmen of Committees	10 (13)*
County Presidents	3 (10)*
Guests	21
Delegates	51
Alternates	23
Members	64
Honorary Member	1
Total	<u>185</u>

\* Included in officer and delegate count.



# THE JOURNAL

OF

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### CONTENTS—Pages 465-516

#### EDITORIALS—

	Page
A FIRM FOUNDATION .....	465
SUCCESSFUL DEMONSTRATION .....	466
PURPOSE OF EXECUTIVE OFFICER'S PAGE .....	467
PROMOTIONS FOR DOCTORS IN SERVICE .....	467

#### THE WAR—

Initial Military Rank for Physicians, September 15, 1942 .....	468
Helpful Hints .....	469
Hamilton Farms Emergency Base Hospital No. 1 of New Jersey .....	469
Special Courses for Medical Officers in the Naval Reserve .....	470
No More Than 1,500 People Should Be Served by One Doctor .....	470
Need of Armed Forces for Physicians .....	471
Medical Gas Officer (Eastern States) .....	472
Blood and Plasma Program .....	472
Consultant State Hospital Officer .....	472
Nurse's Aides .....	472

#### ORIGINAL ARTICLES—

SEGMENTAL ENTERITIS—Charles M. Robbins, M.D., and O. Herman Dreskin, M.D., Newark, N. J. ....	473
ON THE POSSIBILITIES AND PRACTICE OF CHEMOTHERAPY IN WAR TIME—John S. Lockwood, M.D., Philadelphia, Pa. ....	479
INTERSTITIAL KERATITIS—Elbert S. Sherman, M.D., F.A.C.S., Newark, N. J. ....	485
THE DIAGNOSIS OF GALL-BLADDER DISEASE—Louis L. Perkel, M.D., F.A.C.P., Jersey City, N. J. ....	488
DISCUSSION—S. Bernard Kaplan, M.D., Newark, N. J. ....	493

#### ORIGINAL ARTICLES—Continued—

	Page
SPONTANEOUS SUBARACHNOID HEMORRHAGE, An Analysis of Fifty Cases—B. A. Hirschfield, M.D., Trenton; A. S. Tornay, M.D., and J. C. Yaskin, M.D., Philadelphia, Pa. ....	494
INTENSIVE ARSENOTHERAPY OF SYPHILIS IN NEW JERSEY HOSPITALS, with Presentation of a Record-Form for the Essential Data on These Cases—Milton I. Roemer, M.D., Trenton, N. J. ....	498
THE MANAGEMENT OF TOXEMIAS OF PREGNANCY. Maternal Welfare Article No. 73—Carl H. Ill, M.D., Newark, N. J. ....	502
A LESSON FROM A DEATH CERTIFICATE .....	504

#### EXECUTIVE OFFICER'S PAGE .....

#### STATE ACTIVITIES—

List of Current Officers and Committee Members .....	506
Meeting Place of the 1943 Annual Meeting... ..	506
Industrial Medicine—Educational Needs in the Field—L. D. Bristol, M.D., Dr. P.H., New York .....	506
With New Jersey Medical Authors .....	507
Supplementary List of Members No. 5 .....	508
Members Serving in the Armed Forces .....	508
State Board of Medical Examiners .....	509

#### OBITUARY—

Dr. Warren Hastings Smith .....	510
---------------------------------	-----

#### BULLETIN BOARD .....

#### THE BOOK SHELF .....

#### TUBERCULOSIS ABSTRACTS .....

Roster of Officers, Advertising Page 3A

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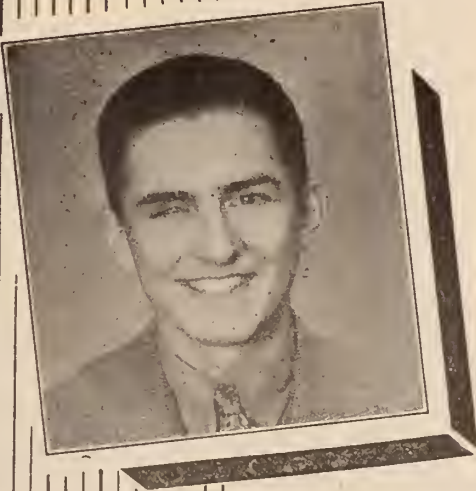
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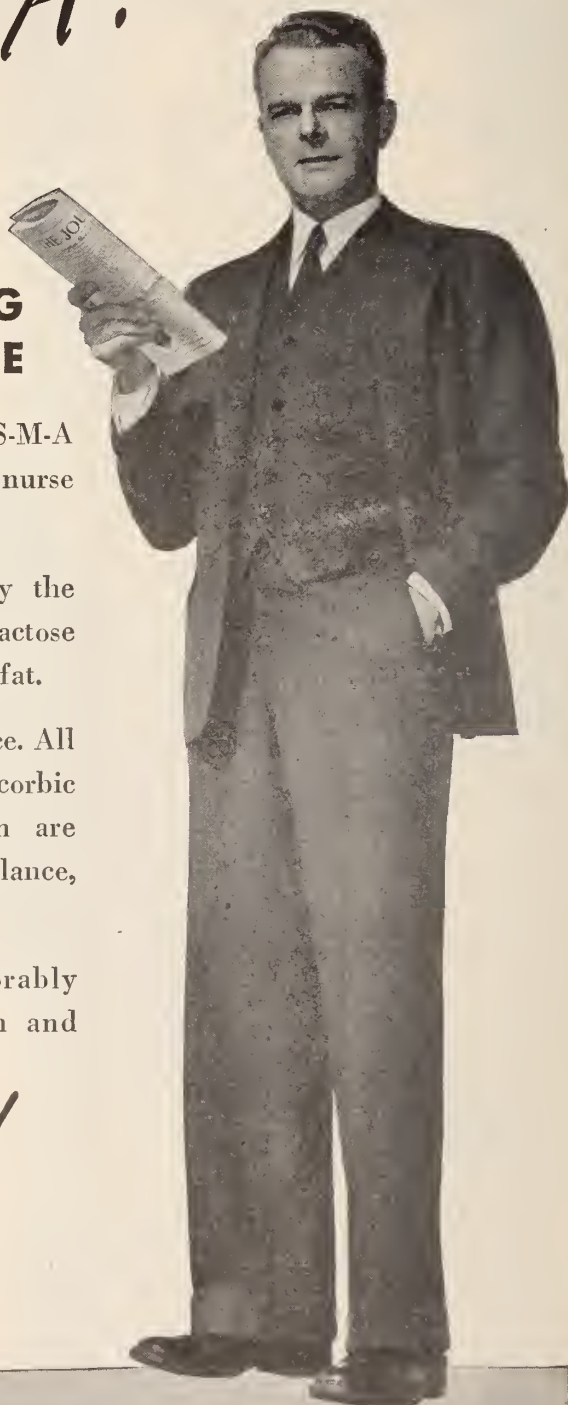
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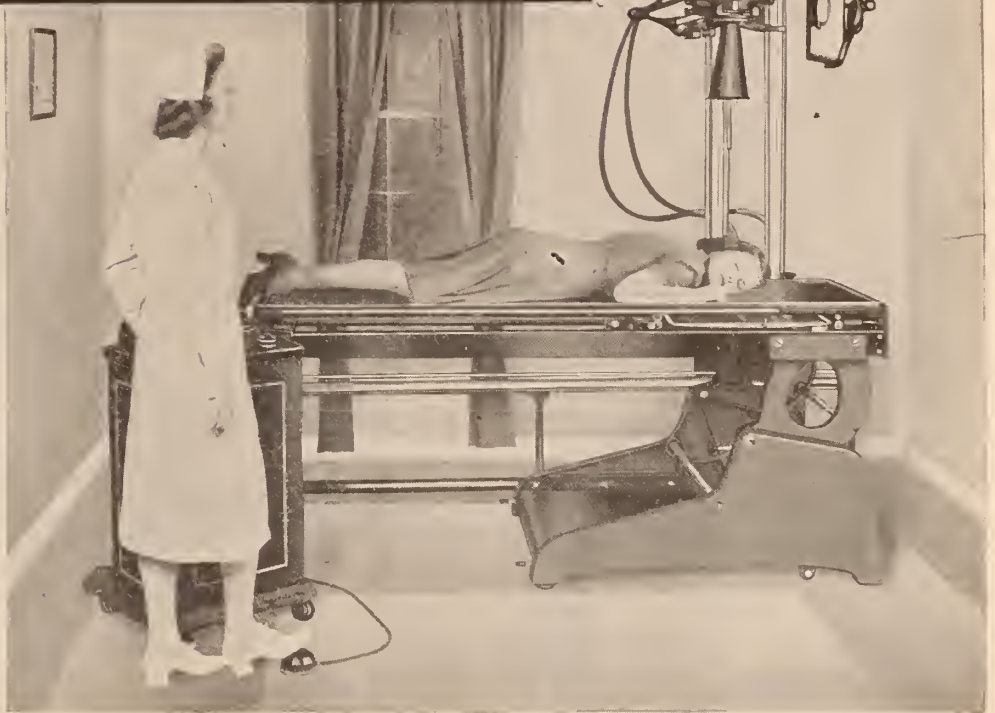
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\*S-M-A, a trade mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil, with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

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*"has practically remade  
the lives of some  
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\*TRADE MARK REG. U. S. PAT. OFF.

1. McEachern, D.: Canadian Med. Ass'n. J., 45:106, 1941.

2. Lennox, W. G.: Med. Ann. Dist. Cal., 10:461, 1941.

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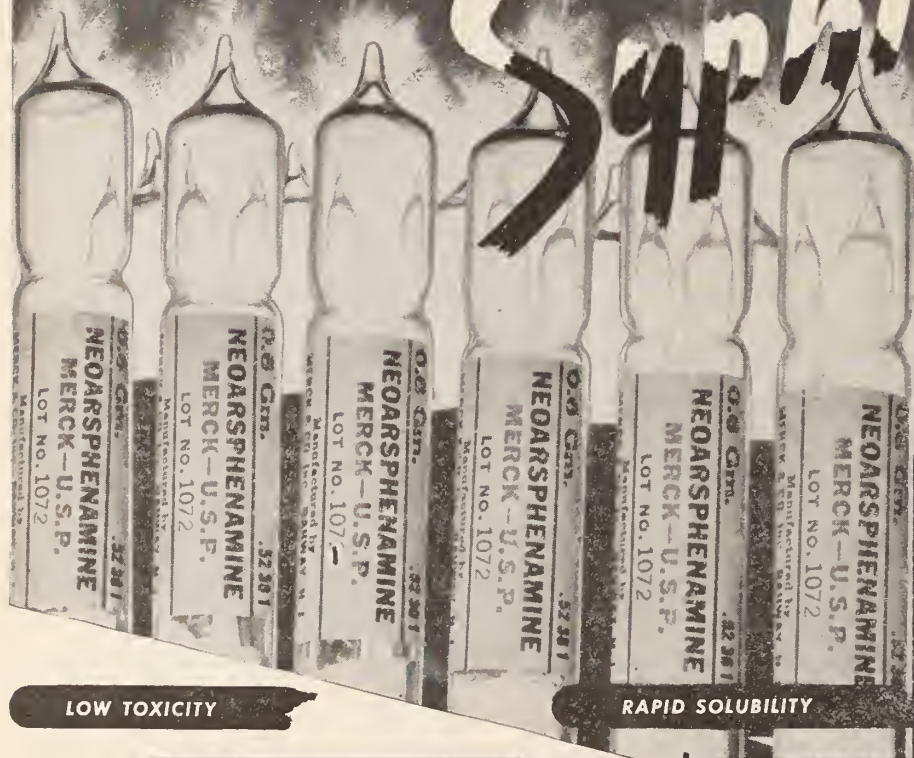
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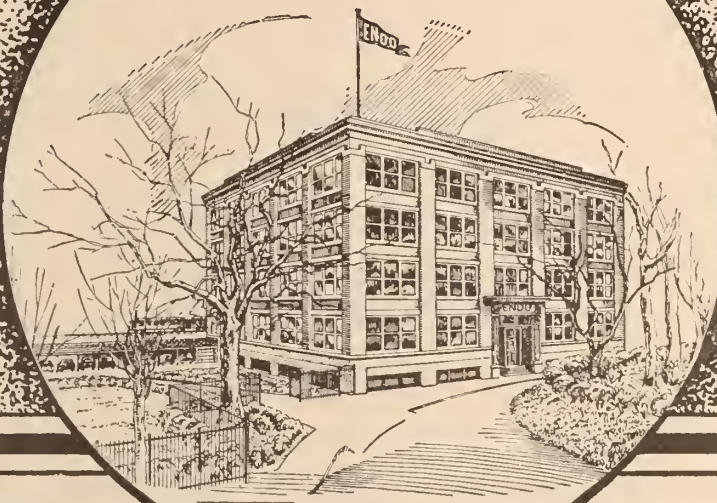
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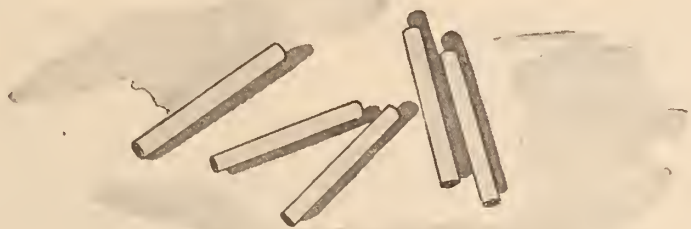
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\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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The Better Vision Institute will conduct a tremendous advertising campaign during the next year—with full pages in "Life", "Saturday Evening Post", "Collier's", "Time", "American", and "Nation's Business" using the above theme "Vision for Victory".

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THIAMINE (Vitamin B <sub>1</sub> ) . . . 0.6 mgm.	REDUCED IRON 7.5 mgm.
RIBOFLAVIN (Vitamin B <sub>2</sub> ) 0.9 mgm.	CALCIUM . . . 220.0 mgm.
NIACIN AMIDE . . . . . 6.0 mgm.	PHOSPHORUS 145.0 mgm.
PANTOTHENIC ACID . . . 2.8 mgm.	COPPER . . . . . 0.3 mgm.
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CEREVIM is enriched with thiamine, riboflavin, niacin, calcium pantothenate, calcium and iron; and contains in each one-ounce serving the complete daily recommended allowances\* for thiamine, riboflavin, niacin and iron for infants and children 1 to 3 years of age, in addition to the other nutrients listed above.

The ingredients of Cerevim are blended uniformly in a pre-cooking process. Cerevim is an excellent source of the vitamin B complex and iron. It is a good source of calcium. Cerevim contains 19.4% protein.

The chemical components and the vitamin content of CEREVIM are checked regularly at the Lederle Research Laboratories, where biological chemists collaborate in new investigations designed to keep pace with developments in the field of nutrition.

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\*As recommended by Committee on Foods & Nutrition, National Research Council, May, 1941.

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Tomatoes for Kemp's Sun-Rayed Brand Tomato Juice are no ordinary field tomatoes. They are a special strain developed through 23 generations of scientific tomato culture and grown in one locality—the rich sugar tree loam soil of north central Indiana. All the tender solids of the whole, carefully cored tomato are converted into juice by Kemp's patented process No. 1746657. Enjoy Kemp's Sun-Rayed in your own home and recommend it with confidence as an excellent source of vitamins A and C and a good source of vitamin B<sub>1</sub>. The Sun-Rayed Company, Frankfort, Indiana.

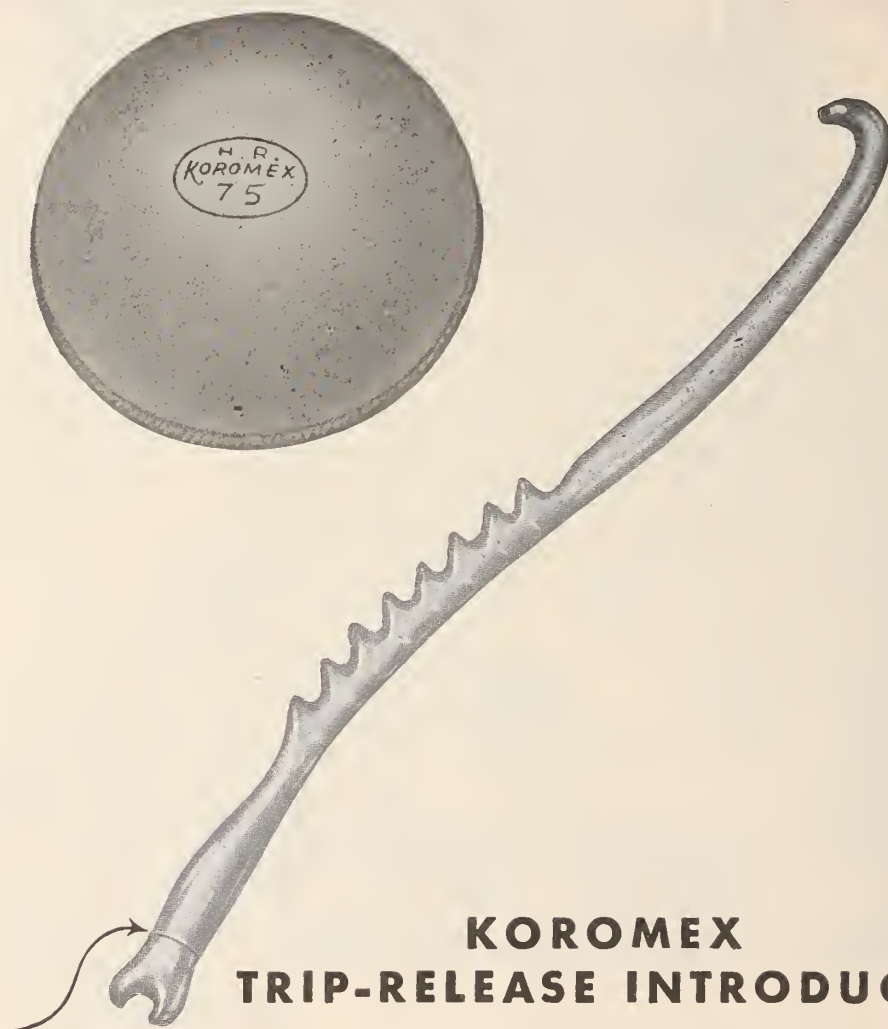
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\*Trade Mark Reg. U. S. Pat. Off. Word “Digifolin” identifies the product as digitalis glucosides of Ciba’s manufacture.

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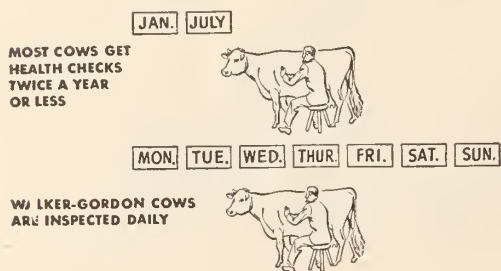


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● 54% of our customers tell us that they started buying Walker-Gordon Certified Milk *because you, their doctors, recommended it.*

We're proud of that. Yes, and we want to *keep* Walker-Gordon known as *the world's finest milk.*

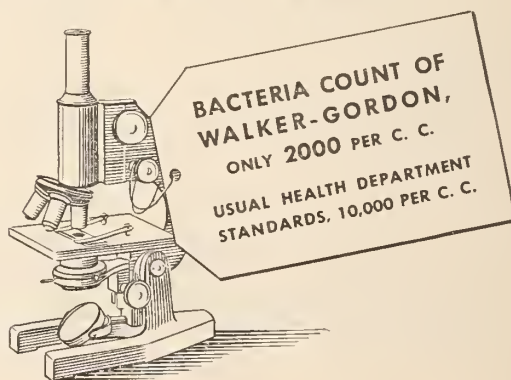
That's why we take such extraordinary purity precautions on our farms. For instance, Walker-Gordon cows get *daily* health checks—instead of semi-annual.



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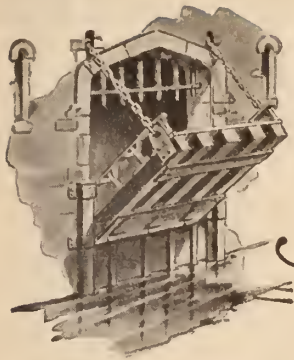


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Any potent drug should be administered under medical supervision, and Benzedrine Sulfate\* is no exception.

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*\*Brand of amphetamine sulfate*



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## Normal Adrenal Cortex

The cortex of the adrenal gland is essential for life in human beings and in all animals which possess this gland. Its removal is fatal within a few days.

## Tuberculosis of the Adrenal

The original description of Addison's disease attributed the condition to tuberculosis of the adrenal. Recent autopsy series show that there may be other causes and that these account for a considerable proportion of the cases.



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Sterile Solution Adrenal Cortex Extract (Upjohn) is an extract of adrenal glands from domestic animals, containing the cortical steroids essential for the maintenance of life in adrenalectomized animals, but so purified that only traces, at the most, of epinephrine are present. Each cc. contains not less than 50 dog units of cortical activity (2.5 rat units) when assayed by the method of Cartland and Kuizenga (American Journal of Physiology 117:678, 1936).

Sterile Solution Adrenal Cortex Extract (Upjohn) is of value in cases of Addison's disease or of adrenal cortex insufficiency, and in surgical procedures involving the adrenal gland, such as removal of cortical tumors, as a prophylactic measure to prevent the development of symptoms of adrenal cortex insufficiency.

*Sterile Solution Adrenal Cortex Extract (Upjohn) is supplied in 10 cc. size rubber-capped vials as a sterile solution for injection.*



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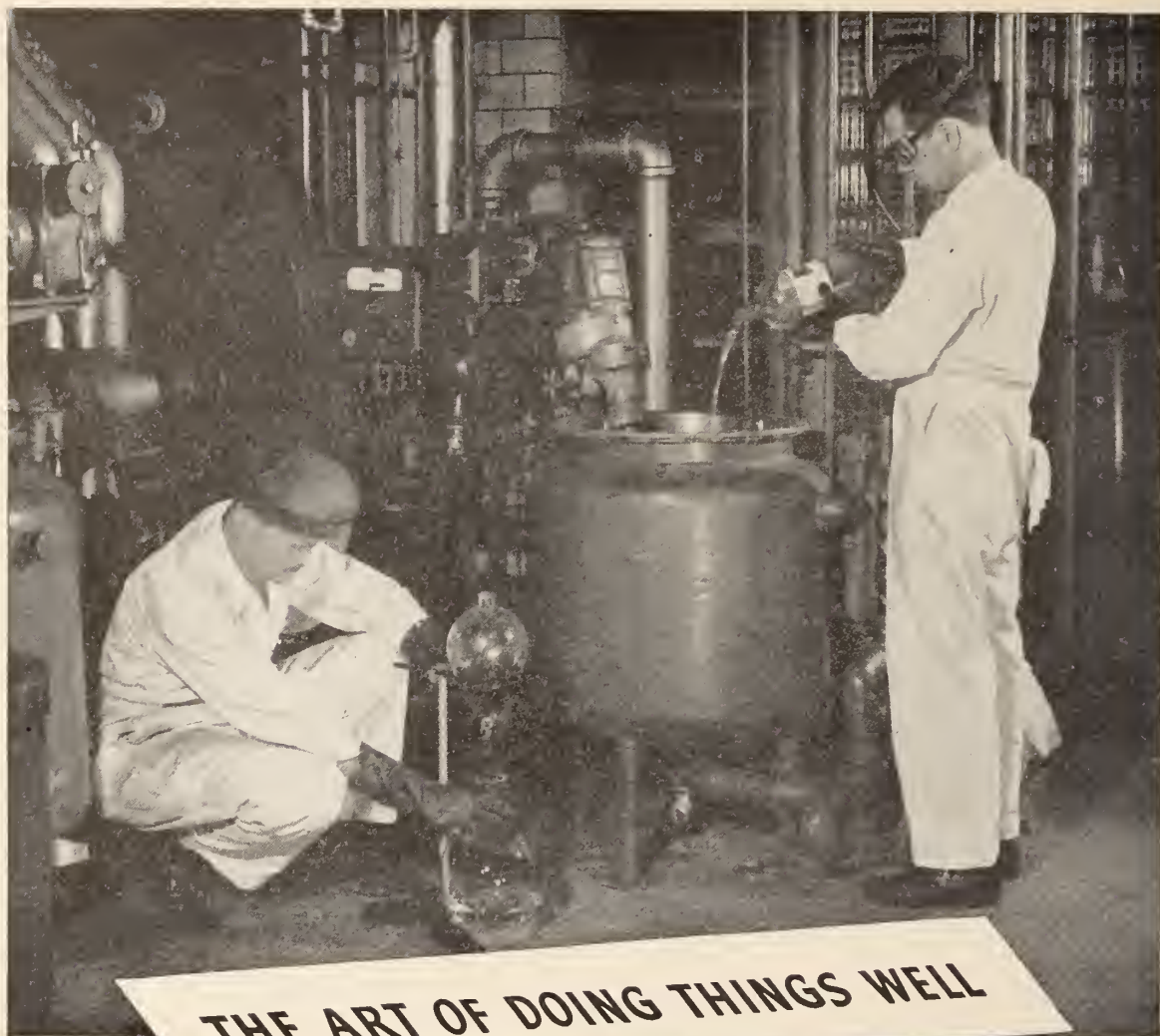


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# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

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UNDER THE  
DIRECTION OF THE  
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor  
IN ACTIVE SERVICE A. U. S.

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

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SEPTEMBER, 1942

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## A FIRM FOUNDATION

The future of Medicine will in a large measure be determined during the crisis through which the world is now passing in which the physician is in great demand. The prevention and control of disease and the care of those human beings already diseased or physically defective were never so urgent a problem. This opportunity for the medical profession to again prove its worth—in war as well as in peace—we cannot allow to pass without a complete and convincing public demonstration of the ability, devotion, sincerity and unity of organized medicine. Those of our members who serve with the Armed Forces have a right to expect their colleagues who for proper reasons are left to serve at home, to demonstrate the same unflagging devotion to duty and sacrifice which will be shown by those who serve at the front and in other assigned posts of duty. This dem-

onstration of public service is new only in the scale on which it is provided and in the sense that it is an organized effort by the several professions which together furnish to the public what is called medical service.

The physician is the basic unit in all medical service. His skill and judgment are being made more widely available through the help of those whose special training relieve him of responsibility in their assigned field of competence. When we shall have come through the emergency, we cannot but realize that new values are likely to be assigned by the medical men and women themselves to certain beliefs and efforts involved in the *distribution* of medical care. Periodic assays of our professional services we ourselves have always demanded. With increasing realization of the need we are now being forced to improve the distri-



bution aspects of our services. The doctor is no longer called in by the family as a last resort in illness or injury as in the early days. The education and experience of the public have been greatly extended. So have communication and transportation. Telephones and automobiles have increased the doctor's area of availability. His increased professional knowledge and experience have expanded his scope of service. He now has competent co-workers and technicians in his well-equipped office, and in the hospital with its special equipment he has additional help when in need of such facilities.

In the war services the doctor will find the best type of hospital and equipment and many able colleagues. He will also find and use executives of ability with staffs to provide for his needs, arrange his schedules and permanently record his results. There too are available sanitarians who periodically study and improve the environmental conditions under which his patients live. These sanitarians lessen the hazards to which the troops are exposed in the field and in camp. These patients will not delay in coming to the doctor and they will not expect such personal sacrifice of the doctor's time to which he is rightfully entitled, except in emergencies, for rest, recreation and

study. The doctor will find none of the worries over uncollectible accounts, though his income may not be at the maximum he once enjoyed. This will be a new experience for many physicians and no claim is made that all of our members will like it. They will at least better understand some of the pros and cons of Group Medical Service which is a current topic of discussion in medical circles—a subject much confused with that emotionally loaded and none too clearly defined term "Socialized Medicine", which has no part in this discussion.

The Medical Society of New Jersey is this month entering upon a new year of activity. The war demands are determined and the pattern set by the Government. Our duty is to fit our services in this pattern and carry on to victory. Our Society's activities will be curtailed, but we must keep alert and aware of our obligations and meet them to the best of our ability. We must think and plan for the future in definite and concrete terms and with economic and practical ways and means to get results. This is a time for teamwork, with the Executive Board of Trustees discharging their responsibility as leaders, and our President proving his ability to rally our membership for service and support during this his year of highest honor and prestige.

---

### SUCCESSFUL DEMONSTRATION

Due to the large increase in employment and the higher wages now being paid, especially in war industries, there is a reported decline in free clinic visits, and an increased demand upon the time of the private physician remaining in practice to look after the civilian population. In view of these pertinent facts there is an opportunity that should be grasped by every private practitioner of medicine to demonstrate, to those who voluntarily seek his services, the claim constantly

made by the profession—first, that the quality of service given to private patients is vastly superior to that furnished in any other way.

Second, that the personal interest manifested by the physician in the diseases and defects of his own patients, provides not only the necessary medical services but also a sense of personal security which is readily recognized and appreciated by the patient.

Third, that the personal relationship

existing between the private patient and his doctor is of prime importance in the recovery of the patient, and that this service is not only appreciated by the patient but is a part of his demand for medical service.

In view of these beliefs of the profession, out of their long experience in dealing with ailing and injured humanity, it behooves every practitioner of medicine in his daily work with his individual patients to convincingly demonstrate the validity of these claims to himself and to

his patients, so that they may support these contentions voluntarily in a sincere endeavor to spread these benefits through personal recommendation to their friends in need of such services. Here is the opportunity for our members not only to practice the type of medicine which has brought the sickness and death rates in America to a point which emphasizes our leadership among the nations, but which will convince those skeptics who feel that even greater benefit may be provided in any of the several other ways they periodically propose.

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### PURPOSE OF EXECUTIVE OFFICER'S PAGE

Full-time devotion to the Society's affairs and problems provides adequate time and exceptional opportunity for study and thought on the Society's business, and for friendly discussion with leaders in other state and community programs having health implications. The Executive offers, on the Executive Officer's Page (page 505), some comments and suggestions as food for thought and subjects for discussion by our members. On such subjects the medical profession must determine and express the prevailing opinion of the members and especially of their approved leaders. There are phases of medical service dis-

tribution and other subjects relating to health protection in which others may have a background of training and experience which better fits them to render an opinion. We should seek and hear such opinions for what they may be worth, and in turn we should, upon request, express our own honest convictions. Where facts are available these will outweigh most opinions except as to the significance of the facts and deductions to be made therefrom. The Executive seeks only to stimulate thought and discussion of pertinent subjects. The final decisions are made by the duly elected Trustees and Delegates.

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### PROMOTIONS FOR DOCTORS IN SERVICE

Announcement has been made by the Surgeon General's Office that in the Army the policy of promotion of those men already in service to higher ranks is to be followed, and men coming into the service will, as a rule, be accepted in the lower grades and given the opportunity to prove their value in Army service,

which would entitle them to higher ranks. This is a sound policy and is part of the Army practice to make achievement the basis of promotion in that service. The memorandum of the Surgeon General, which is effective September 15, 1942, is printed on page 468 of this *Journal*.

# THE WAR

## INITIAL MILITARY RANK FOR PHYSICIANS, SEPTEMBER 15, 1942

A memorandum prepared in the Office of the Surgeon General, United States Army, about August 15th, on the subject of initial appointment and promotion is quoted below:

"The Surgeon General of the Army published detailed information concerning policies governing the initial appointment of physicians as medical officers on April 23, 1942. Necessary changes are given wide publicity, at his request, in order that the individual applicants, and all concerned in the procurement of medical officers, may always know the status of such appointments.

"The current military program provides for a definite number of position vacancies in the different grades. The number of such positions must necessarily determine the promotion of officers already on duty and, in addition, the appointment of new officers from civilian life. Such appointments are limited to qualified physicians required to fill the position vacancies for which not equally well-qualified medical officers are available. *Such positions calling for an increase in grade should be filled by promotion of those already in the service, insofar as possible, and not by new appointments.*

"If this policy is not followed, it would definitely penalize a large number of well-qualified Lieutenants and Captains already on duty by blocking their promotions which have been earned by hard work. In view of these facts, *it has been deemed necessary to raise the standards of training and experience for appointment in grades above that of First Lieutenant.*

"With this in view, the Surgeon General has announced the following policy which will govern action to be taken on all applications after September 15th, 1942:

"All appointments will be recommended in the grade of First Lieutenant with the following exceptions:

### CAPTAIN

"1. Eligible applicants between the ages of 37 and 45 will be considered for appointment in the grade of Captain by reason of their age and general unclassified medical training and experience.

"2. Below the age of 37 and *above* the age of 32, *consideration* for appointment in the grade of Captain will be given to applicants who meet all of the following minimum requirements:

- "a. Graduation from an approved medical school.
- "b. Internship of not less than one year, preferably of the rotating type.
- "c. Special training consisting of three years' residency in a recognized specialty.

"d. An additional period of not less than two years of study and/or practice limited to the specialty.

"3. Eligible applicants who previously held commissions in the grade of Captain in the Medical Corps (Regular Army, National Guard of the United States, of Officers Reserve Corps) *may be considered* for appointments in that grade provided they have not passed the age of 45 years.

### MAJOR

"1. Eligible applicants between the ages of 37 and 55 *may be considered* for appointment under the following conditions:

- "a. Graduation from an approved school.
- "b. Internship of not less than one year, preferably of the rotating type.
- "c. Special training consisting of three years' residency in a recognized specialty.
- "d. An additional period of not less than seven years of study and/or practice limited to the specialty.
- "e. The existence of appropriate position vacancies.
- "f. Additional training of a special nature of value to the military service.

"2. Applicants previously commissioned as Majors in the Medical Corps (Regular Army, National Guard of the United States, of Officers Reserve Corps) whose training and experience qualify them for appropriate assignments may be *considered* for appointment in the grade of Major provided they have not passed the age of 55.

### LIEUTENANT COLONEL AND COLONEL

"In view of the small number of assignment vacancies for individuals of such grade, and the large number of Reserve Officers of such grades who are just being called to duty, such appointments will be limited. Wherever possible, promotion of qualified officers on duty will be utilized to fill the position vacancies.

"Much misunderstanding has arisen concerning recognition by Specialty Boards and membership in specialty groups. It will be noted that mention is not made of these in the preceding paragraphs. This is due to the variation in requirements of the different Boards and organizations. Membership and recognition are definite factors in determining the professional background of the individual, but are *not* the deciding factors, as so many physicians have been led to believe.

"The action of the Grading Board, established by the Surgeon General in his office, is final in tendering initial appointments. Proper consideration must be given such factors as age, position vacancies, the functions of com-



mand, and original assignments. All questionable initial grades are decided by this Board. Due to the lack of time, no reconsideration can be given.

"There are in the age group 24-45 more than a sufficient number of eligible, qualified physicians to meet the Medical Department requirements. It is upon this age group that the Congress has imposed a definite obligation of

military service through the medium of the Selective Service Act. The physicians in this group are the ones needed *now* for active duty. The requirements are immediate and imperative. Applicants beyond 45 years may be considered for appointment only if they possess special qualifications for assignment to positions appropriate to the grade of *Major* or above."

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## HELPFUL HINTS

Lieut. Henry A. Davidson, M.C., A. U. S., who is now in Australia, has in a recent letter offered the following helpful suggestions out of his experience as a soldier in the foreign field:

"Be sure that your army bedding-roll is completely stocked. Buy either an air mattress or a sleeping bag, preferably the former, unless you get an arctic assignment. Purchase a foot-pump for inflating the air-mattress. The pump is a ball of rubber with a hose attached. It is advisable to have both an air pillow and a kapok pillow. You can keep your kapok pillow in the bed-roll and the collapsible air pillow in the musette bag.

"A rain coat of thin rubber can be folded to fit in your musette bag. The latter is furnished to those assigned to foreign service. Buy high hubber boots, also leggings. An old style campaign hat from the last war is strongly advised because it keeps water from running down your neck in a rain storm, and at the same time, mosquito netting can be hung from the brim. This is impossible with any other type of hat. These hats are not issued as modern equipment, but can be purchased from the Boy Scout posts or from the salvage dump at the Quartermaster store.

"The musette bag should contain enough to enable one to live out of it for two or three weeks; i. e., a change of linen, shaving gear,

soap, tooth-brush, tooth-paste, handkerchiefs, bouillon cubes, rain coat, mess kit, corn pads, sewing kit, matches, toilet paper and a mirror.

"If you go overseas take plenty of soap, at least twenty-four cakes, and plenty of wooden matches. Gillette shaving blades can be obtained everywhere, but not Gem or Schick blades. Take a year's supply of the latter. Electric razors are of no use abroad, and are forbidden on ship, as are cameras and radios. Brushless shaving cream is more practical. For maneuvers and bivouacking, shaving soap works better with cold water. Shaving sticks are better than tubes or jars. They are more economical of space and do not become dented.

"Buy two field jackets, one of leather (Air Corps style) and one of the regular officer's jacket. Two overseas caps are needed, one woolen and one of cotton. Get one or two pairs of high shoes as well as one pair of low oxfords. Take four pairs of trousers of the summer uniform type, and the same number of olive drab trousers. Two pair of pinks are necessary. One tunic will be enough. The Sam Browne belt is not necessary, but looks impressive. Two woolen belts and two blouses are advised.

"*You will be allowed only four pieces of baggage*, so take a small-sized army trunk, a suitcase of the Valpack style, a musette bag and the bed roll."

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## HAMILTON FARMS EMERGENCY BASE HOSPITAL NO. 1 OF NEW JERSEY

A two-story carriage house on the 6,000-acre estate of Mrs. Charles Saydam Cutting, Gladstone, N. J., which has been converted into an emergency hospital for civilians evacuated from metropolitan hospitals in case of bombings, formally was opened here yesterday. The base, first of its kind in the country, is one of several emergency units to be set up in Drew University, Princeton University, Lyons Hos-

pital and other places in "least vulnerable areas".

Mrs. Cutting presented the casualty station to the State Defense Council, represented yesterday by Director Leonard Dreyfuss and Dr. Charles H. Schlichter, of Elizabeth, State Director of the Emergency Medical Service. The conversion of the large carriage house is estimated to have cost \$750,000. Many of the gold

and silver trophies and expensive trappings which used to be on exhibit there were sold by Mrs. Cutting to pay for the project.

Dr. Schlichter termed the facilities better than in many hospitals. There is space for 300 to 400 beds in an emergency. The hospital will be staffed by doctors and nurses loaned by hospitals in Jersey City, Newark and other North Jersey cities. Forty-four nurse's aides from Somerset and Morristown hospitals will be capped here tonight and will be on duty regularly.

In order to test the facilities yesterday several convalescent patients were brought here from other hospitals. Dr. Schlichter reported that they were delighted with their treatment and surroundings.

The hospital has an operating room and about six large wards, with a kitchen, staff dining room, quarters for nurses and doctors and a large central room on the second floor, formerly the trophy room. It is equipped with explosion proof switches and has self-charging batteries which can provide emergency lighting in the event power lines are shut off.

The casualty hospital has been named *Hamilton Farms Emergency Base Hospital No. 1 of New Jersey*. Adj. Gen. James I. Bowers, former State Senator from Somerset County, and Dr. Gerald W. Sinnot, director of the base, were in the inspection party which Mrs. Cutting entertained.—*Elizabeth Daily Journal*, Aug. 6, 1942.

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## SPECIAL COURSES FOR MEDICAL OFFICERS IN THE NAVAL RESERVE

It is the policy of the Navy Department when specific needs arise, to order medical officers for courses of instruction in various specialties.

The following special courses of instruction for a limited number of medical officers in the Naval Reserve are now available: Aviation Medicine, Medical Duties with Parachute Troops, Medical Duties in Deep Diving, Psychiatry, Anesthesia, Thoracic Surgery, Neuro-Surgery, Plastic Surgery, Reconstruction Surgery, Physical and Fever Therapy and Duties with Epidemiology and Laboratory Units. Med-

ical officers are not eligible to make application for special courses until they have reported for active duty.

Applications for commissions in the Naval Reserve are made through the Office of Naval Officer Procurement, 33 Pine Street, New York, N. Y., or its branch office, Liberty Bank Building, Buffalo, N. Y.; Navy Recruiting Station, New Haven, Conn.; Albany, N. Y.; Marine Recruiting Station, Syracuse, N. Y., or to Commander W. S. McCann, M.C., U. S. N.R., Strong Memorial Hospital, Rochester, N. Y.

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## SAYS NO MORE THAN 1,500 PEOPLE SHOULD BE SERVED BY ONE DOCTOR

### PROCUREMENT AND ASSIGNMENT SERVICE BOARD AGREES ON THIS MINIMUM COVERAGE UNTIL SPECIAL COMMITTEE COMPLETES STUDIES

Until special studies now under way are completed, it has been agreed that, for general medical service, approximately one "effective" physician to fifteen hundred population is the minimum coverage that should be provided, the board of Procurement and Assignment Service for Physicians, Dentists and Veterinarians says in the July 11 issue of *The Journal of the American Medical Association* in answer to the question of how many people in a community can be served by one man. Limited specialists are not included in the above basic figure. It is explained that a special committee of the Procurement and Assignment Service is making studies to serve as a basis for the determination of minimum quotas of medical service

which should be retained for the civilian population.

Some of the other questions and answers contained in the special statement are as follows:

"Q. Will the Procurement and Assignment Service protect a doctor from the draft?

"A. The Procurement and Assignment Service was not established to protect anybody from anything. Its function is to enroll physicians, dentists and veterinarians and assign them to the positions in which their services will be of greatest value to the nation in the war emergency. This function obviously parallels the responsibilities of Selective Service, but the officials of the Selective Service have welcomed the cooperation of the Procurement and Assignment Service in dealing with these pro-

professional groups. To implement this cooperation, General Hershey issued a memorandum to Selective Service boards asking them to secure through the state director of Selective Service the recommendations of the Procurement and Assignment Service wherever they are considering the classification of a physician, dentist or veterinarian. Hence, if a doctor has enrolled with the Procurement and Assignment Service, his Selective Service board will be so advised and a recommendation for his deferment, until his services are needed in a professional capacity, will be made.

"Q. If a physician is physically disqualified for a commission, is he still subject to the draft?

"A. The physical requirements for officers are higher than they are for enlisted men, but under the modified requirements for 'limited service' in the Medical Corps most, if not all, physicians who meet the requirements for enlisted men will be eligible for commissions. If not, the physician concerned should consult the chairman of his State Procurement and Assignment Service Committee relative to service in a war industry or some other essential civilian service.

"Q. In determining the number of physicians needed to care for the civilian population, are rural communities considered on the same basis as larger cities?

"A. A special committee is now working on the determination of minimum quotas of physicians for civilian medical care. In their studies consideration will be given to the density of the population, the ease of transportation, the availability of hospital service and other factors.

"Q. Is the local draft board or the Procurement and Assignment Service to determine whether a doctor is necessary in his local community?

"A. The legal responsibility for deciding whether any individual who is registered with Selective Ser-

vice shall be given deferment rests with his local Selective Service board. However, General Hershey has directed local boards, when considering the classification of physicians, dentists or veterinarians, to secure the advice of the state committee of the Procurement and Assignment Service as to whether the individual under consideration is 'essential' for the care of the civilian population in his community or whether he can be considered available for service elsewhere.

"Q. How many physicians are there in the United States under 35 years of age? Under 45?

"A. Of the 152,923 physicians in private practice in the continental United States, 37,753, or 24.7 per cent are under 35 years of age, 35,240, or 23.0 per cent, are 35-44 years of age, 26,573, or 17.4 per cent, are 45-54 years of age, 26,076, or 17.1 per cent, are 55-64 years of age, 11,915, or 7.8 per cent, are 65-69 years of age, 8,112, or 5.3 per cent, are 70-74 years of age and 7,233, or 4.7 per cent, are 75 and over.

"Q. Do you expect the needs of the armed forces to be filled by voluntary enlistment? If not, what is to be the procedure?

"A. It is the firm conviction of the directing board of the Procurement and Assignment Service that the physicians of this country will willingly accept the assignments requested of them in meeting the medical needs of the nation during the war emergency. The executive order of the President establishing the Procurement and Assignment Service states that Mr. McNutt may 'instruct the Agency to draft legislation, which may be necessary to submit to the Congress providing for the involuntary recruitment of medical, dental and veterinary personnel, in the event the exigencies of the national emergency appear to require it.' The directing board, however, has given no thought to such legislation because it is convinced that it will not be necessary."

## JOURNAL AGAIN EMPHASIZES NEED OF ARMED FORCES FOR PHYSICIANS

**SAYS WINNING THIS WAR IS MOST IMPORTANT SINGLE OBJECTIVE EVER PLACED BEFORE MEDICAL PROFESSION OF THE U. S.**

Pointing out that there is a distinct disparity between the applications from physicians coming through various routes directly to the Office of the Surgeon General of the Army, to the Air Force and to the Navy and the number that ought to be immediately available to meet our war needs, *The Journal of the American Medical Association*, in its July 25 issue, says: "Let us realize that the winning of this war is the most important single objective ever placed before the medical profession of these United States and give to our nation the same complete, wholehearted, voluntary service on which the nation has learned to depend in the past.

"The needs of the armed forces will require that every physician under 45 years of age and physically fit who has not been stated by his

state board of procurement and assignment to be engaged in an essential occupation must be made available to the armed forces. The Selective Service Act makes available to the armed forces every male citizen in the United States under 45 years of age. The physician who waits for the draft to pick him up certainly is in an unenviable light before his profession but even more in his own self respect. Little is to be gained by hesitating or holding back until the call comes, as it eventually will have to come from the boards of the Selective Service if the needs of the armed forces are not satisfied.

"The Procurement and Assignment Service for Physicians, Dentists and Veterinarians was developed to aid the medical profession in de-



termining for itself equitable distribution of medical service during the emergency. By utilizing its facilities, hospitals are being enabled to retain essential members of their staffs, industries are being enabled to retain necessary physicians and medical schools are being enabled to hold a sufficient number of their faculties to continue medical education. Every-

thing possible is being done to enable individual communities to retain enough physicians to provide needed medical services for the civilian population. If, however, the armed forces do not get the medical personnel that they require the civilian population might be compelled to yield physicians who are doing their utmost to maintain civilian health. \* \* \*

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### MEDICAL GAS OFFICER (EASTERN STATES)

Dr. David D. Rutstein, Chief of the Cardiac Bureau of the New York State Department of Health, Albany, has been appointed to the staff of the Medical Division, Office of Civilian Defense, Washington, D. C., as Medical Gas Officer to organize instruction for physicians of Eastern States in the medical aspects

of chemical warfare. Dr. Rutstein is a graduate of Harvard University and Harvard Medical School, and has been in the New York State Department of Health at Albany since 1937. He is now on leave from that position to devote his full time as Medical Gas Officer of the Eastern States.

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### BLOOD AND PLASMA PROGRAM

Dr. Fred Bryan, Rochester, N. Y., is the Consultant on the Blood and Plasma Program for the First, Second and part of the Third Regions of Civilian Defense. Under the program recently launched by the Medical Division of the Office of Civilian Defense of the United States Public Health Service to pro-

vide plasma and blood for the treatment of civilians injured in warfare, was made a part of the program of the Office of Civilian Defense. The regional consultants are available to advise hospitals on technical problems related to the establishment of these blood and plasma banks.

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### CONSULTANT STATE HOSPITAL OFFICER

Dr. Emil O. Frankel of the Division of Statistics and Research, State Department of Institutions and Agencies, Trenton, N. J., has been appointed Consultant State Hospital Officer in the Medical Division of the Office of Civilian Defense. The duties of such hospital officers are: to survey rural hospital facilities suitable for use as Emergency Base Hospitals, to supervise personnel arrangements for the

Base Hospitals and reception centers for evacuated civilians, to collaborate with State Chiefs of the Emergency Medical Service in controlling movements of medical and nursing staffs as well as of casualties in any situation affecting Emergency Base Hospitals and to perfect arrangements for transporting patients evacuated from Casualty Receiving Hospitals.

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### NURSE'S AIDES

Nurse's Aides are recruited by the American Red Cross in coöperation with local Civilian Defense Volunteer Offices. Each local chapter of the Red Cross which sponsors Nurse's Aide training has a Nurse's Aide committee on which there is a representative of the local Civilian Defense Volunteer Office. The local chief of Emergency Medical Service is also a member of this committee, which recruits desirable applicants, selects hospitals to serve as training centers, and organizes and maintains a placement service for aides who have completed their courses.

The training course of Nurse's Aides includes 80 hours of instruction presented in

seven weeks. The first half is given in a Red Cross chapter house or other suitable place. After this probationary period, the instruction is continued in hospitals selected as training centers. When the course is completed, the Red Cross serves as a placement agency for the assignment of Nurse's Aides to duty in hospitals, clinics, health departments, school health and field nursing services.

Each Nurse's Aide agrees to give 150 hours of service in each calendar year, preferably within a three-month period. In case of need for war service, Nurse's Aides must be prepared to serve locally in the emergency for as long a period as they are needed.

## ORIGINAL ARTICLES

### SEGMENTAL ENTERITIS\*

CHARLES M. ROBBINS, M.D., and O. HERMAN DRESKIN, M.D.  
Newark Beth Israel Hospital, Newark, N. J.

Regional enteritis was first described as a clinico-pathological entity in 1932 by Crohn, Ginzburg and Oppenheimer. They defined it as a disease of the terminal ileum affecting mainly young adults, characterized by necrotizing and cicatrizing inflammation with stenosis of the lumen, and frequently with multiple fistulae. The cardinal clinical features were fever, diarrhea, emaciation, and right iliac fossa mass.

This original description is still accurate, though incomplete, for it is now recognized that this same process may involve separately or diffusely the small or large intestine, although the most commonly involved segment is the terminal ileum.

#### THERAPY

Medical and expectant treatment is the only form of therapy available for diffuse ileojejunitis (Crohn and Yunch, 1941). Some mild cases of the ordinary terminal ileitis may remain stationery or improve slowly, although the majority progress slowly towards exhaustion and death (Crohn, 1936). Supportive therapy alone is indicated in the acute stage of the disease if diagnosed correctly (Lehman, 1939; Crohn, 1939, and Snierson and Ryan, 1941). Sulfaguanadine has been ineffectual to date.

Appendectomy has practically the same end results as the above, except that external fistulas often follow this procedure.

Of the short-circuiting procedures, Colp and Ginzburg (1941) stated that ileo-transverse colostomy with exclusion of proximal ileum is the procedure of choice. Up to the report of their series, the most optimistic results of ileocolostomy in the literature conceded only 50 per cent successes, probably because exclusion was not done in the majority. They stated that it is the method of choice above resection

in all cases except those with large ileo-sigmoidal fistulas. In twenty-two cases so treated they had no deaths, one unimproved case where a large ileo-sigmoidal fistula was present, nineteen apparent cures, and two recurrences. Snierson and Ryan (1941) affirmed the opinions of Colp and Ginzburg.

Resection in one or two stages or by a Mickulicz type of procedure has been the method productive of the highest percentage of cures up to 1941. In 1939 Crohn considered it far superior to the short-circuiting operation. Shapiro's review (1939) listed a gross mortality of 7.2 per cent of 290 cases resected with 68 per cent cures, 7.9 per cent mortality in 88 short-circuited cases with 31 per cent cures, 4.3 per cent mortality in 70 cases treated by simple appendectomy with 56 per cent cures.

Marshall (1940) at Lahey Clinic preferred the Mickulicz type of resection and presents a zero mortality in thirteen cases so treated with recurrences in two cases.

Clark and Dixon's (1939) review of forty-four cases treated by resection with three deaths and twenty-five cures, eleven by exclusion procedures, with four deaths and eight apparent cures; these men preferred resection to short-circuiting.

#### REPORT OF CASES

Case 1.—A. N., white male, aged twenty-one, admitted 5-25-40, complained chiefly of pain and bulge in right lower abdomen. He had an appendectomy at the Iverson Memorial Hospital on 3-3-40 for chronic right lower quadrant pains of six weeks duration. Following operation, he was well up to ten days before admission, at which time he noted a bulge over the incision. Constipation appeared, followed by pain in this area.

The past and the family history were irrelevant.

Physical examination showed a chronically ill, asthenic young man, with blood pressure 96/50, reddened fauces, a fresh scar in the right lower quadrant with bulge beneath it 6" x 3", slightly tender. A few small glands were present in the right groin, with fullness in the right pelvis present on rectal examination.

\* Presented before the Clinical Society of the Newark Beth Israel Hospital, December 3, 1941.



Pre-operative laboratory work was as follows:

The urine was essentially negative.

Blood—19,200 W.B.C. with 52 polys, 15 lymphocytes, 10 monocytes, 2 basophils and 21 stabs. 70 per cent Hb (Sahli).

3,700,000 R.B.C.

Urea nitrogen 14 mgm. per cent.

Sugar 83 mgm. per cent.

Stool—Bloody mucus about stool—center positive for occult blood.

The pathological report from Iverson Memorial Hospital of 3-30-40 described an appendiceal mass covered with purulent exudate, showing edema, subacute and chronic inflammatory changes more marked in the periappendiceal tissues than in the appendix. The impression was that it was a granuloma, possibly a regional ileitis.

X-ray of the chest showed healed tuberculosis of the left and right upper lobes.

A barium enema showed irregular filling of the terminal ileum, with the suggestion of a mass in the right iliac fossa.

Laparotomy was performed 5-28-40. A large adherent mass was found extending from the last six inches of the ileum through the cecum to the middle of the ascending colon, with considerable fluid present in the right gutter. The mesentery about the involved bowel was filled with large lymph glands. Resection of eight inches of the terminal ileum, the cecum and ascending colon, and half of the transverse colon was performed followed by a side-to-side ileo-transverse colostomy. The abdomen closed in layers without sulfanilamide, and one cigarette drain was inserted.

The surgical pathology reports was as follows:

Gross—Specimen consists of 50 cm. of ileum together with the cecum and part of the ascending colon. The serosal surface of the intestine is congested, roughened and dulled. The wall of the ileum is thick, measuring from 4-5 mm. in diameter, and stiff. The mucosa is thick, forming numerous transverse folds. Scattered through the ileum are several small ulcers measuring 5 x 6 mm., with their long axis parallel to the long axis of the intestine. The lowermost part of the ileum, the cecum and the ascending colon show a markedly thickened, firm wall and a mucosa which has completely lost its normal appearance, presenting an irregular outline. There are scattered, ulcerated areas, the largest of which, at the level of the ileo-cecal junction, measures 3 cm. in diameter. The base of the ulceration is depressed and shows a star-like retraction. The mesentery in this region is markedly thickened, contracted and firm. On section, it contains areas of yellow fatty tissue interspersed with areas of firm, greyish-red tissue. In the appendiceal region there is a stump measuring 5 cm. in length and about 5 mm. in diameter.

Received separately is another portion of small intestine measuring 8 cm. in length and 2½ cm. It presents changes similar to those in the first-described portion.

Microscopic examination reveals the entire wall of the ileum markedly thickened. The mucosa shows considerable interstitial edema and an increased number of polymorphonuclear leucocytes and plasma cells.

The lumina of the glands are wide and in places filled with pus cells. The mucosal lymph-follicles are large and show marked reticular hyperplasia.

In one place the mucosa is broken by a narrow, crater-like defect which is filled with fibrin and polymorphonuclear leucocytes. This ulcer can be traced down to the muscularis where there are dense collections of polymorphonuclear leucocytes, forming an intramural abscess (Fig. 1). Aside from this, the submucosa, muscularis and subserosa show diffusely scattered zones of edema, chronic inflammatory infiltration and extensive fibrosis, separating the original layers of the intestinal wall or entirely replacing them.

The inflammatory infiltrations have in many places an appearance similar to that of tubercles, forming circumscribed nodules made up of round cells and epithelioid cells. Some of them show large basophilic histiocytes and multinucleated giant cells. They show no evidence of central necrosis. No acid-fast bacilli are found in the sections stained with Ziehl-Neelson stain.

Within the area of fibrosis, numerous markedly thickened arteries are found with occasional perivascular lymphocytic infiltrations. Tubercle bacilli could not be found.

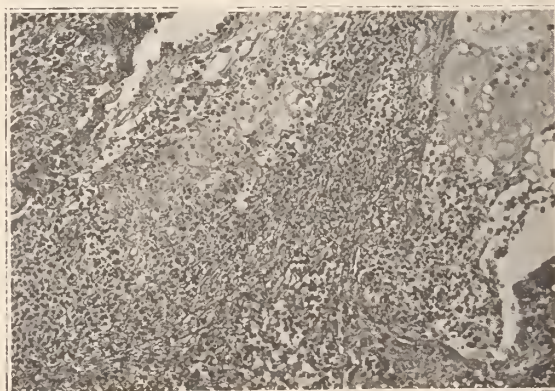


FIGURE 1.

The mucosa is broken by a crater-like defect which is filled with fibrin and polymorphonuclear leucocytes. This extends into the muscularis.

The final diagnosis was segmental enteritis.

The post-operative course was stormy with spiking temperature curve throughout, fecal fistulas appearing on the third post-operative day and jaundice appearing on the seventeenth post-operative day. Progress was gradually downhill and the patient died in coma on the thirty-sixth post-operative day.

The post-operative laboratory data showed mainly a persistent leukocytosis of 13,000—30,000; a persistently positive Widal in varying titers from 1:80 to 1:320, negative blood and stool cultures, 100 mgm. per cent blood cholesterol and 33 mgm. per cent blood cholesterol esters.

The essential findings at autopsy were:

1. Decubitus ulcers.
2. Numerous sinus tracts undermining abdom-



inal wall, with one large fistulous tract opening into the terminal ileum.

3. Many adhesions in abdomen, especially about terminal ileum and transverse colon.

4. Ileocolostomy widely patent.

5. Abscess 3½ cm. in diameter, filled with thick yellow pus, below left dome of diaphragm.

Case 2.—A. C., white female aged thirty-five, admitted 4-14-41, complaining chiefly of abdominal pain and diarrhea. She had had an appendectomy two years before, at which time she was told that she had "ileitis". Since then she had been suffering with recurrent sharp pains in the right lower abdomen. Frequent attacks of the "bumps" were noted, particularly after food ingestion, i. e., palpable spastic intestinal masses travelling across the abdomen could be felt followed by sharp cramp-like pains. She had attacks of diarrhea every few months lasting several weeks, and attended by 4-5 yellow liquid stools each day.

The past and family history were non-contributory.

Physical examination showed a thin adult female not appearing ill, blood pressure 118/70, tenderness in right lower quadrant and hypogastrium, firm tender mass 4 x 10 cm. just above the right Poupert's ligament. Visible peristalsis was seen at each examination.

Pre-operative laboratory work was as follows:

Urine—Negative.

Hb (Sahli)—68 per cent.

Stool—Positive for occult blood, negative for typhoid and dysentery bacilli.

A gastro-intestinal series showed distention of terminal jejunum and entire ileum, ileum was dilated to five times normal size and completely atonic, considerable delay in intestinal mobility was noted, with barium still present in ileal loops after forty-eight hours, adhesions of ileum suggested.

Laparotomy was performed on 4-16-41. The terminal foot length of ileum was found thickened, indurated and greyish-white with mesenteric lymphadenopathy about it, the proximal loops of ileum were dilated and distended. The terminal eighteen inches of ileum, the cecum and the ascending colon were resected, ileo-transverse colostomy was performed, sulfanilamide power placed in abdomen, and the wound was closed in layers without drainage.

The surgical pathology report was as follows:

Gross—Specimen consists of a continuous portion of terminal ileum and cecum measuring 27 cm. in length. The lumen of the ileum is funnel-shaped, constricting towards the ileo-cecal valve. At the proximal end, the circumference measures 12 cm. and tapers down to ½ cm. in diameter for the terminal 7 cm. Here, on reconstruction, the lumen is noted to barely permit the passage of a thick probe. The serosal surface over the entire bowel is dull, lusterless and injected. This is most marked in the ileum. In the region of the constriction, the serosal surface presents a number of scar-like, retracted areas and enlarged and tab-like appendices epiploicae. In this region, the bowel is kinked on itself and bound down by fibrous adhesions to the adjacent bowel. The mesentery of the ileum is thickened; within it are noted numerous enlarged,

semi-firm, succulent lymph nodes which, on section, are composed of greyish-pink medullary tissue. Tags of fibrous adhesions are noted in the cecal region.

On opening the abdomen, in the region of the ileocecal valve, semi-firm, polypoid structures are seen projecting into the lumen. These vary in size from 1-12 mm. in diameter; they are mostly confined to the region of the ileocecal valve, but some polypi are noted within an area 2 cm. distal to the valve. In an area 10 cm. proximal to the valve, the mucosal folds of the ileum are edematous, thickened, and the surface is roughened and granular. The color varies from a light to dark reddish hue. In this area, in contrast to the valvuli conniventes of the more proximal portion, which are transverse in position and 2 mm. in width, these valvuli assume

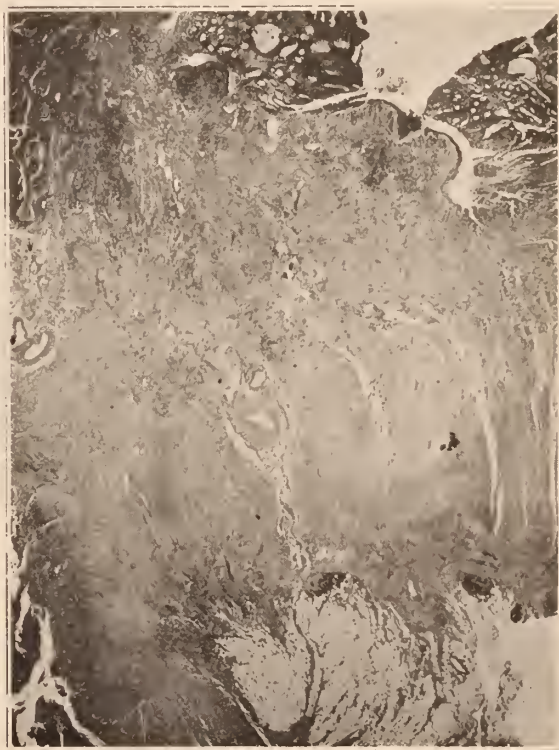


FIGURE 2.

Ulceration of the mucosa with numerous lymphoid aggregates in the adjacent region. Note a section of a sinus tract in the left lower corner of the illustration.

a cobble-stone appearance and the folds appear to run in a more longitudinal direction. In this area, the wall of the ileum varies from 1-2 cm. in thickness, in contrast to that of the proximal ileum which is 3 mm., and that of the cecum, which is 5 mm. in thickness. The mucosa of the ileum proximal to the area just described presents slightly thickened and indurated folds over whose surface are deep scattered numerous superficial erosions, varying from 1-10 mm. in diameter. The bases of the ulcers are finely granular and dark greyish-red

in color. In addition, there is noted a number of mottled greyish and red areas within the mucosa measuring up to 2 cm. in diameter. The appendix is absent.

**Ileum**—Microscopically, the mucosa next to the lesion shows a great abundance of lymphoid follicles. There is a rather abrupt transition toward the area of most severe involvement of the wall of the ileum. The mucosa is markedly thickened due to an increase in interstitial tissue, and in places deep ulcers are present (Fig. 2). The glands are pushed apart, distorted, widened and in places are apparently regenerating as indicated by some cellular atypism, nuclei of various staining quality and an increased number of mitotic figures. The interstitial tissue is densely infiltrated with lymphocytes, numerous plasma cells and scattered polys. In places only remnants of glands can be recognized, in others the infiltration reaches the mucosal surface causing ulceration. This cellular infiltration extends deep into the muscularis propria, separating or entirely replacing the muscle bundles. In these deep areas of infiltration there is an abundance of plasma cells. Scattered throughout the muscularis and subserosa there are also smaller foci of round-cell infiltration which look like lymph follicles with large germinal centers. Some of them show proliferation of histiocytic cells, fibroblasts and few giant cells. Thickened subserosal vessels and proliferated nerves are noted.

**Lymph node:** Shows marked edema of the lymphatics. The follicles show some large germinal centers. There is no evidence of any granulomatous lesion.

A final diagnosis of segmental enteritis was made.

The post-operative course was uneventful, and the patient was discharged 4-28-41, the thirteenth post-operative day.

A seven-month follow-up finds her feeling well, with no gastro-intestinal complaints, and having gained thirty-four pounds.

**Case 3.**—N. S., white female, age forty-four, complained chiefly of generalized abdominal cramps of month duration before admission, which localized later in right side of abdomen. She had had occasional constipation. She had had night sweats for the past eight months, slight dyspnea on exertion, and a moderate leucorrhea for the past four or five years.

The past and family history was non-contributory.

Physical examination revealed a well-developed, well-nourished adult female not appearing ill, blood pressure 120/80, tonsillar hypertrophy, protuberant rounded abdomen with firm, ovoid, non-tender mass 4 cm. in diameter, 5 cm. to right of umbilicus.

Pre-operative laboratory findings were as follows: Urine—Essentially negative.

Blood—9,500 W. B. C. with 76 polymorphonuclear leucocytes, 2 stab cells, 15 lymphocytes, 6 monocytes, 1 eosinophil.

4,300,000 R. B. C.

85 per cent Hb (Sahli).

Wassermann and Kline tests—Negative.

Blood urea 10 mgm. per cent.

Blood sugar 94 mgm. per cent.

X-ray studies of the gastro-intestinal tract showed narrowing and induration of the terminal ileum, the cecum and the ascending colon.

Laparotomy was performed 6-4-41. The cecum was found plastered to the abdominal wall, hard and indurated; six inches proximal to the ileo-cecal junction on the ileum another palpable hard mass was found, apparently a part of the intestinal wall. Resection was performed of the terminal eighteen inches of ileum, the cecum and ascending colon; ileo-transverse colostomy was then done, and four grams of sulfanilamide powder were placed in abdomen.

The surgical pathology report is as follows:

**Gross**—Specimen consists of a 60 cm. portion of terminal ileum, cecum and appendix, and ascending colon. The serosal surface of the ileum is smooth and glistening, except for two areas, measuring approximately 3 cm. in diameter, situated approximately 25 and 35 cm. above the ileo-cecal valve, where the serosa is opaque, finely granular, thickened and shows punctate hemorrhages. Corresponding to the proximal area, the ileal mucosa shows irregular ulcerations, congestion, pinpoint hemorrhages and fistulous tracts extending into the mesenteric attachment for a distance up to 1 cm. The wall of the bowel in these areas is thickened and measures 1 cm. in thickness, in contrast to the remaining portion where the bowel measures 4 mm. The ulcerative lesion extends over the entire circumference of the bowel and measures 2 cm. in length, and for a distance of 3 cm. on either side of the lesion the mucosa is smooth and devoid of the normal valvuli conniventes. Corresponding to the distal peritoneal area, the ileal mucosa shows a star-like, irregular, retracted area measuring 1 cm. in diameter and extending for about half the circumference of the bowel in this region. The surrounding mucosal folds are congested, edematous and thickened. The wall is firm and measures 6 mm. in diameter. For a distance of 2 cm. on either side of the lesion, the valvuli conniventes are flattened. In the terminal 10 cm. of the ileum the mucosal folds are absent, the mucosa presenting a velvety, finely granular appearance and a yellowish tint. The wall in this area measures approximately 4-5 mm. in thickness and appears slightly indurated.

The serosal lining of the cecum, appendix and ascending colon is lusterless, injected and in places covered with a fibrinous exudate. Irregular, star-like retractions are noted here, most marked in the cecal region. The cecal area is occupied by an irregular, nodular, firm tumor mass measuring 8 x 6 x 5 cm. On opening, an hour-glass shaped constriction is noted in the region of the ileo-cecal valve, measuring 7 cm. in length, 1 cm. in diameter at its narrowest portion and 3 cm. at its widest portion. Here the mucosa presents irregular ulcerations and intervening, edematous elevations. A number of fistulous tracts extending into the mesenteric fat are noted measuring up to 2½ cm. in length and 3 mm. in diameter. The mucosa in areas is granular and hemorrhagic. The mucosa of the ascending colon is smooth. The wall of the cecum measures up to 2 cm. in thickness. It is composed of whitish, firm tissue. The appendix is involved in the same process. It measures 8 cm. in length and



is pyramidal in shape, measuring 3 mm. at the base and 8 mm. at the tip.

A microscopic section of ileum shows a small portion of normal intestinal wall with only slight congestion of the capillaries. The change to the pathological lesion is abrupt. It shows a large ulcer of the mucosa and muscularis mucosae. The edges of the ulcer are undermined. The base of the ulcer is densely infiltrated predominantly with plasma cells, histiocytic cells and polymorphonuclear leucocytes. Corresponding to this ulcerated area the muscularis is infiltrated with diffusely scattered foci of cellular infiltration. These foci, which frequently have the appearance of tubercles, are made up of lymphocytes, epithelioid cells, and giant cells resembling the Langhan's variety (Fig. 3). A considerable number of large giant cells of the Langhan's type are found within these nodules. There seems to be a hypertrophy of the outer layer of the muscularis propria and in a few places proliferation of nerves.

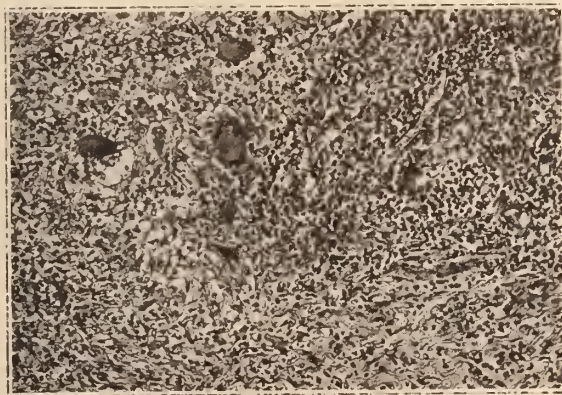


FIGURE 3.

"Tubercle-like" focus composed of lymphocytes, epithelioid cells and giant cells resembling the Langhan's variety.

The subserosa shows also some granulomatous infiltration and fibrous thickening. The lymphatics are distended and filled with a homogeneous eosinophilic substance. Section from the main lesion in the cecum shows changes similar to those described above, but much more extensive. The intestinal wall is tremendously thickened. The mucosa is absent in many places. The thickening of the intestinal wall is largely due to the presence of a loose granulomatous tissue which replaces large areas of the muscularis propria. It is made up of fibroblasts and young histiocytes with large vesicular nuclei. Many newly formed capillaries are noted. This tissue is diffusely infiltrated with lymphocytes, plasma cells and numerous polymorphonuclear leucocytes. Giant cells are scattered throughout. Necrotic remnants of muscle fibres are found. Those parts of the muscularis propria which are not involved by the granulomatous infiltration show a peculiar basophilic staining of their muscle fibrils.

The subserosa is thickened due to fibrosis. It shows numerous collections of plasma cells, lymphocytes and histiocytes, preferably in perivascular and perineural locations. The lymphnodes show some

hyperplasia and a few scattered nodules made up of the same granulomatous tissue as seen in the intestinal wall. No tubercle bacilli are found.

*A final diagnosis of segmental enteritis was made.*

The post-operative course was marked by fever up to 102° for eight days, diarrhea on the fifth, sixth and seventh days controlled by opium. Patient was discharged in good condition on 6-18-41, the fourteenth post-operative day.

A six-month follow-up finds her feeling well, and having gained fourteen to fifteen pounds weight. She had had a mild diarrhea gradually decreasing up to a month ago, but now her stools are formed and she has one a day.

Case 4.—T. G., white female, aged forty, admitted on 3-6-42, complained chiefly of intermittent cramps of 6 weeks duration. These cramps appeared in various portions of the abdomen and were unrelated to food intake. Anorexia, occasional nausea and vomiting, distention and intermittent diarrhea were associated. Moderate weight loss had occurred during this period.

She had had nephritis in 1925 and pyelitis in 1929. Family history was non-contributory.

Physical examination showed a well-nourished white female, not acutely ill; blood pressure 130/60; soft systolic localized murmur at apex, accentuated second aortic sound; a movable, round, regular, non-tender mass was palpable in lower abdomen up to three fingers above symphysis and extending towards the right iliac fossa; varicosities of both lower extremities were present.

Pre-operative laboratory findings were as follows:

Urine—65 mgm. albumin.

Blood—10,200 W. B. C. with 59 polymorphonuclear leucocytes, 6 stab cells, 30 lymphocytes, 3 monocytes, 2 eosinophils.

4,150,000 R. B. C.

80 per cent Hb (Sahli).

Blood urea—11 mgm. per cent.

Blood sugar—92 mgm. per cent.

X-ray studies of the small and large intestines were reported as indicative of tumor of the cecum.

Laparotomy was performed on 3-9-42. A large, firm, irregular mass was found about the cecum. The cecal wall was fixed to the wall of the proximal transverse colon by an adhesion; a small pedunculated, nodular, fibroid tumor was present near the right cornu of the uterus. The terminal ileum, ascending colon, and half of the transverse colon were mobilized and resected; the stumps were closed and side-to-side ileo-transverse colostomy was performed, the tumor on the uterus was excised and the raw surfaces peritonealized; two grams of sulfanilamide and a cigarette drain were placed in the peritoneal cavity; the abdomen was closed in layers.

The surgical pathology report was as follows:

Gross—Specimen consists of terminal ileum, cecum and ascending colon. The terminal ileum measures approximately 15 cm. in length and 3 cm. in diameter. The serosal surface shows finely congested vessels and several slightly elevated, pinkish, miliary-like nodules measuring up to 2 mm. in diameter and raised approximately ½ mm. above



the surrounding serosa. The mucosal surface shows an irregular, superficially ulcerated area measuring approximately  $1 \times .5 \times 2$  mm. In the region of the ileo-cecal valve, the normal architectural pattern of the mucosal folds is lost; it is smooth in areas, and has a cobblestone-like effect in others. The wall in this area is thickened and measures up to 6 mm. in thickness, as compared to 2 mm. elsewhere. The pericecal region is nodular, semi-firm and shows irregular retractions and depressions. On opening the cecum is occupied by a constricting, multiple polypoid mass. These polypi are semi-firm, pinkish-grey, mostly confluent and measure up to 1.5 cm. in diameter. On section, they are composed of semi-soft pinkish and greyish-white tissue. The wall in this region measures up to 4 cm. in thickness and is of semi-firm consistency. Several fistulous tracts are seen extending from the mucosa into the markedly thickened subserosa which shows areas of greyish-brown softening. The tracts measure up to 2 cm. in length and are approximately 2 mm. in diameter. The ascending colon measures approximately 40 cm. in length and 7 cm. to 10 cm. in circumference. The mucosal surface, in areas, is smooth and shows irregular, streaky and pinhead-sized hemorrhages and severe fistulous tracts extending into the subserosa and similar to the ones described above. There are marked adhesions between the loops of small bowel and the transverse colon. Several small, pinkish, discrete and confluent lymph nodes are noted in the mesentery.

Microscopic examination showed a granulomatous process involving terminal ileum and cecum with ulceration and fistula formation. There are lesions which are suggestive of tuberculosis. No acid fast bacilli are found. The picture was similar to that found in Case 3.

A diagnosis of segmental enteritis was made.

X-rays of the chest were negative for tuberculosis.

The post-operative course was marked by a moderate diarrhea, persistent slight drainage from the lower angle of wound which gradually subsided. Patient was discharged on 4-16-42, the thirty-eighth post-operative day in good condition.

A follow-up one month later finds her without symptoms and with her wound completely healed.

#### DISCUSSION

Four cases of regional enteritis were subjected to primary resection plus ileo-transverse

colostomy. Case 1, a poor operative risk on admission, died on the thirty-sixth post-operative day of exhaustion, fecal fistula and subphrenic abscess. Cases 2 and 3 were discharged two weeks post-operative in good condition and with no complications except milk diarrhea in 3. Case 4 was discharged after five weeks of convalescence and is free of symptoms at present.

After reviewing the literature and our own experiences, it is our opinion that case 1 might have had a successful outcome with the simpler procedure of ileo-transverse colostomy with exclusion, plus sulfanilamide powder in the abdomen.

The fact that two of our cases were subjected to previous appendectomy is worthy of note. This is in agreement with the review of Shapiro, who noted 112 cases out of a total of 413 which had a previous appendectomy performed. It should be emphasized, therefore, that in cases with an appendectomy scar and continued lower intestinal complaints, segmental enteritis must be considered in the differential diagnosis.

#### SUMMARY AND CONCLUSIONS

Four cases of regional enteritis have been described. Primary resection plus ileo-transverse colostomy was the procedure adopted in all four, with one death in fifth post-operative week. The three remaining cases are symptom-free and in good general health for periods of seven and one-half, six months and one month respectively.

The authors are grateful to Drs. William Antopol and William Levison for their collaboration in the study of the pathological material.

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## ON THE POSSIBILITIES AND PRACTICE OF CHEMOTHERAPY IN WAR TIME

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The Medical Society of New Jersey, April 21, 1942.

A review of the official mortality statistics of the U. S. Army during the last war<sup>1</sup> provides the inescapable conclusion that most of the deaths among soldiers, apart from those killed in action, were due to infection. Furthermore, a considerable portion of the burden of lengthy hospitalization and disability of wounded men was a consequence of the prolonged suppuration of wounds of the soft parts and bone. Men with compound fractures were disabled for an average period of 235 days, and the case fatality rates for battle-caused compound fractures of the femur, lower leg, and humerus were 25 per cent, 13.5 per cent and 10 per cent, respectively. When one considers that the casualties among our troops received in their treatment the benefit of the hard-won experience of our Allies, one can appreciate what must have been the shocking complexity of the problem which confronted the British Army Medical Corps at the outset of the last war, before the sound principles of surgical treatment of wounds due to high-velocity projectiles had become established. This subject has been presented nowhere more graphically than by the late Sir Almroth Wright, the distinguished English bacteriologist, in the "Medical History of the World War".<sup>2</sup> He is herewith quoted at length:

"It may here be useful to describe succinctly the state of things that prevailed in the hospitals at the base in the early months of the war.

"Every wound—one may say every wound, for there was hardly an exception—was very heavily infected, and presented, each according to its type, the features summarized below:

"1. *Avulsing wounds*, i. e., wounds produced by the avulsing of great pieces of flesh.—In these the originally naked surface of the

wound was coated with black and stinking sloughs, while the trough was occupied by a putrid and almost faecal-looking discharge in which every kind and variety of microbe was pullulating.

"2. *Perforating and fracturing wounds*, i. e., wounds in which the projectile had in its passage encountered bone and broken this to pieces.—Of these wounds there were two varieties. In the one the fragmented bone had been blown clean out, leaving an irregularly crateriform wound of exit, at the bottom of which were pockets between the muscles and extensive fissures in the fractured bone. In the other the explosive impact had hollowed out in the interior of the limb a cavity of quite irregular contour with blind passages running in between the muscles, the cavity being cut off, or to all intents and purposes cut off, from the exterior by hernia of muscle, supplemented in some cases by a valvular closing over the skin. Such valvular closure was the result of the limb being at the moment of wounding in the flexed position, and being afterwards in bed brought into the extended position.

"In both varieties of the perforating and fracturing wound the cavity contained fragments of bone, pieces of projectile, portions of clothing, frayed ends of muscle and suchlike, all these lying embedded in a corrupted pus in which every conceivable microbe was luxuriantly growing.

"3. *Sutured amputation wounds*.—In these the dead spaces left by the bringing together of the flaps were filled with a putrid discharge in which there was a luxuriant mixed bacterial growth.

"4. Lastly, there were what may be described as *implunging wounds*, i. e., wounds produced by nearly spent pieces of shell or shrapnel. The projectile, together with the clothing it carried in, was here implunged into the soft parts, and these had closed round the

1. The Medical Department of the U. S. Army in the World War, Volume 15, part 2. Washington, 1925.

2. The History of the Great War, Volume on Medical Pathology, pp. 32-77. London, 1923.

foreign body, leaving no encompassing cavity or communication with the exterior.

"In all these different types of wound the infection had in practically every instance extended beyond its focus of origin. Streptococcal invasions of the encasing tissues were all but universal, and diffuse cellulitis was specially frequent in unopened implunging wounds, this being no doubt due to the microbes being here implanted directly into connective tissue or muscle instead of, as in other types of wounds, into a cavity extraneous to the tissues.

"Not infrequently these streptococcal infections of the tissues had led on to septicemia.

"Tetanus, also, was of frequent occurrence, and it occurred in connection with all the different types of wounds.

main causes of death, and their relative incidence. As is shown, approximately 51 per cent of the deaths were due to diseases (of which three-fourths were primary and secondary pneumonias), 32 per cent were killed in action, and the remaining 17 per cent were deaths in hospitals due to injuries. Table II indicates what the availability of sulfonamide therapy would have meant in relation to respiratory diseases, and meningitis. Practically all of the deaths from respiratory diseases were due either to primary lobar pneumonia, or to pneumonia occurring as a secondary complication of epidemic influenza or of upper respiratory tract infection.<sup>3</sup> Current experience in civilian hospitals shows that deaths occur only rarely among patients in the third and fourth decades, and among patients receiv-

TABLE I  
CAUSES OF DEATH, RATIOS, AND DAYS LOST—U. S. ARMY, WORLD WAR I.  
(April 1, 1917—December 31, 1919)

Causes	Absolute Numbers	Ratios per 1000 Strength	Proportion of Total	Days Lost Annual Ratios per 1000
Diseases .....	58,119	14.08	50.9%	41.60
Non-battle injuries .....	5,591	1.35	4.9%	4.49
Battle injuries .....	13,691	3.32*	12.0%	11.61
Killed in action .....	36,694	8.89*	32.1%	
Total .....	114,095	27.64	100.0%	57.70

\*Almost all of these casualties occurred in France during 1918, so that the ratios shown in the table are much lower than if calculated in terms of the strength of the A. E. F. This must be recognized in making comparison with Table III.

"Even more ghastly were the numerous cases of gas gangrene."

Let us suppose that the development of the sulfonamides had occurred twenty-five years earlier; as a matter of fact sulfanilamide *was* synthesized by Gelmo in 1908 but its chemotherapeutic possibilities were unhappily not recognized until 25 years later! If our troops had had the benefit not only of the principles of surgical debridement, but of the sulfonamides as well, the statistical picture would unquestionably have been far different. The accompanying tables provide an admittedly crude, but in the writer's opinion, conservative, estimate of the salvage of soldiers which would have been provided by the application in 1917-1919 of our present knowledge of the sulfonamides.

Table I is concerned with an analysis of the

ing sulfonamide therapy within 24 hours of the onset of the disease. Since both of these conditions would be met in the Army experience the estimated mortality rate of three per cent is conservative. This reduction from the actual mortality rate of 22.2 per cent would have provided in connection with lobar pneumonia alone a salvage of 2,130 men per million armed strength per year. In considering bronchopneumonia it is recognized that sulfonamide therapy is not as effective in mixed bacterial infections, especially where the staphylococcus is concerned, and one cannot be certain what proportion of pneumonias secondary to epidemic influenza would have responded to therapy. Therefore, the estimated mortality rate for sulfonamide treated bronchopneu-

3. The Medical Department of the U. S. Army in the World War, Volume 12, Washington, 1925.



monia is placed at 10 per cent. These figures were similarly applied in calculating the revised mortality rates for influenza and bronchitis, adopting the official estimate that two-thirds of the deaths from these infections were due to bronchopneumonia and one-third to lobar pneumonia. The total estimated salvage from respiratory diseases of 7,869 men per million

sources and the results of treatment in the casualties at Pearl Harbor, added to the growing weight of evidence in civilian hospital experience, justifies the opinion that the major problems of infection in traumatic wounds may be avoided through a proper combination of surgical treatment and sulfonamide therapy. In making the estimates depicted in Table

TABLE II  
INCIDENCE AND MORTALITY RATIOS FOR INFECTIOUS DISEASES IN U. S. ARMY  
(April 1, 1917—December 31, 1919)

Disease	Apr. 1, 1917- Dec. 31, 1919	Apr. 1, 1917-Dec. 31, 1919		Est. Results with Sulfonamides		Estimated Sal- vage per 1000 Men per Year
	Annual Incidence per 1000 Men	Annual Deaths per 1000 Men	Case Fatal- ity Rate	Case Fatal- ity Rate	Ann. Deaths per 1000 Men	
Bronchitis	61.80	0.11	0.18 %	0.05 %*	.031	0.079
Influenza	191.82	5.97	3.1 %	0.88 %*	1.700	4.27
Bronchopneumonia	7.89	2.19	27.6 %	10.0 %	0.790	1.39
Lobar pneumonia	11.09	2.46	22.2 %	3.0 %	0.330	2.13
Total respiratory diseases	272.60	10.73	3.9 %	1.05 %	2.851	7.869
Meningitis (all types)	1.3	0.5	38.4 %	5.0 %	0.065	0.435

\*Based on estimate that two-thirds of deaths were due to bronchopneumonia and one-third to lobar pneumonia, and further that current fatality rates of these complications would be 10 per cent and 3 per cent, respectively.

TABLE III  
INCIDENCE AND MORTALITY RATIOS FOR CERTAIN BATTLE INJURIES  
(HOSPITALIZED PATIENTS) IN A. E. F.—1918

Region	A. E. F. — 1918			Est. Results with Sulfonamides		
	Proportion of Admissions	Ratio per 1000 AEF	Deaths per 1000	Case Fatal- ity Rate	Case Fatal- ity Rate	Deaths per 1000 Armed Strength
Upper extremities	33.0%	62.0	2.4	3.88%	1.0%	0.62
Lower extremities	48.0%	78.0	5.7	7.33%	3.0%	2.34
Abdomen and pelvis	2.0%	3.5	1.5	43.32%	*18.7%	.655
(Bowel injuries)	(0.5%)	(0.9)	(0.65)	(72.20%)	(15.0%)	(0.135)
Thorax	2.7%	4.5	1.1	24.05%	10.0%	0.45
Other regions	14.3%	30.5	2.8	9.17%	5.0%	1.52
Total battle injuries	100.0%	178.0	13.5	7.73%	3.21%	5.585

\*Case Fatality Rate non-bowel injury cases estimated at 20 per cent (same as 1918)  
Case Fatality Rate bowel injury cases estimated at 15 per cent

armed strength per year becomes particularly impressive if it can be applied to an army of the size now contemplated in World War II. The analysis of the mortality from hospitalized battle injuries, in Table III, finds us on somewhat less secure ground in making estimates as to the rôle of sulfonamides. The encouraging reports from British

III the writer takes recognition of the fact that under the actual conditions of warfare the end results could not reasonably be expected to measure up to those obtained in our civilian hospitals. Delay in reaching hospitals equipped to provide definitive treatment, the terrific load upon hospital facilities and personnel during a major drive, and the more severe nature of

battle wounds, would all have conspired to defeat the achievement of optimum conditions. The revised mortality rate for wounds of the upper extremities treated with sulfonamides is placed at 1.0 per cent to allow for an occasional sulfonamide failure, and for late deaths from shock and hemorrhage; for the same reason the rate for wounds of the lower extremities is placed at 3.0 per cent—though if dried plasma had been available as well as drugs to prevent infection, these figures might well have been kept even lower. No reduction in the mortality of abdominal wounds in which peritonitis was not a factor has been allowed even though many of these were undoubtedly complicated by infection. It is estimated that the deaths from peritonitis in bowel-perforating wounds would have been so reduced by the prophylactic sulfonamide therapy as to justify putting this figure at 15.0 per cent. The estimated figure for thoracic wounds is 5.0 per cent in order to allow for deaths due to causes other than empyema. The mortality rates for wounds of other regions have with equal arbitrariness been subjected to a reduction of approximately 50 per cent. These admittedly crude estimates place the total salvage provided by the hypothetical administration of sulfonamides to wounded men in the A. E. F. at 7,915 men per million.

If these estimates in Tables II and III are grouped together, it seems reasonable to affirm that the risk of death for men in army service during the present war is less than half what it was during the last war—assuming similar conditions of warfare. The actual military significance of this change in war-time vital statistics is largely offset by the fact that our enemies are as free to take advantage of advances in medicine as are we and our Allies.

Having thus reviewed at some length the nature of the problem, and indicated our belief that sulfonamide therapy will afford results of great consequence if properly used during the present war, we turn to the practical question: "How does chemotherapy in war-time differ from chemotherapy in peace-time?" Such differences as may exist are accounted for by the basic differences between medical practice as applied to large groups, on the one hand, and

to individuals, on the other. The best treatment for a large group of individuals may not necessarily be identical with the treatment the conscientious and informed physician would apply to the individual patient, under circumstances when adequate time and facilities are available for complete study and careful observation of the individual case. While it is to be hoped that the medical and surgical treatment under emergency conditions will be individualized as much as possible, it would be unrealistic to fail to work out in advance methods of "streamlining" the treatment of certain types of conditions should the necessity arise. The relative homogeneity of the medical population in a military hospital, and the fact that most sick or injured men are diagnosed and treated early, are factors which aid in the simplification of therapeutic methods. On the other hand, the likelihood under emergency conditions of shortages of medical and nursing personnel, and of laboratory facilities, impose the responsibility of avoiding as far as possible the use of complicated methods of treatment which might be safe and, in fact, desirable, in individualized medical practice, but impractical and dangerous under field conditions.

Since sulfonamide therapy is likely to play such an important rôle in wartime medicine and surgery, it is fortunate that it is a method of treatment which lends itself so readily to the type of "streamlined" administration which we have been discussing. Furthermore, we are not called upon to use the sulfonamides in place of other therapeutic methods of definitely established value except possibly for the replacement of serum therapy in all but occasional cases of pneumococcic pneumonia and meningitis. It is both customary and practical to employ sulfonamides *in conjunction with* other medical and surgical procedures of recognized merit.\*

Tables IV and V indicate the author's preference in choice of drugs and dosages for prophylactic and therapeutic use, respectively. Space does not permit of a detailed discussion of the rationale of the specific choices which are designated. Sulfanilamide and sulfadiazine are given preference in systemic prophylaxis because of the low incidence of serious

toxic complications induced by the former and the broad range of effectiveness and low production of unpleasant subjective reactions by the latter. Sulfanilamide is preferred for topical use in clean or contaminated wounds, particularly those which are to be closed post-

tive. Sulfadiazine or sulfathiazole are indicated in the treatment of most established infections because they are more powerful than sulfanilamide and their employment can be justified in spite of their tendency occasionally to interfere with normal kidney function.

TABLE IV  
SIMPLIFIED SCHEME OF SULFONAMIDE PROPHYLAXIS

	Systemic Drug of Choice		SYSTEMIC DOSAGE			Topical Drug of Choice	Remarks
	1st	2nd	Initial Grams	Maintenance Gms.	Hrs.		
Epidemic influenza (severe)	SD	ST	2	1	6		Duration of R depends on complications.
Complicated childbirth . . . .	SD	ST	2	1	6		For deliveries conducted in presence of sepsis or probable contamination.
Penetrating wounds of soft parts and bone . . . . .	SA	SD	SA 4-6 SD 2	1 1	4 8	SA crystals Up to 10 gms.	Employ this regime both before and after surgical treatment.
Wounds of abdomen, thorax and brain . . . . .	SA	SD	"	"	"	Ditto	Ditto.
Intestinal resections, etc. . . .						Up to 6 gms.	Apply SA both within cavity and to wounds of entrance.

SA—Sulfanilamide  
SD—Sulfadiazine  
ST—Sulfathiazole

TABLE V  
SIMPLIFIED SCHEME OF SULFONAMIDE TREATMENT

	Systemic Drug of Choice		SYSTEMIC DOSAGE			Topical Drug of Choice	Remarks
	1st	2nd	Initial Grams	Maintenance Gms.	Hrs.		
Pneumonia . . . . .	SD	ST	3	1	4		Continue 3-4 days then reduce. Type specific serum in resistant cases.
Meningococcic meningitis . .	SD	SA	3	1	4		Ditto.
Severe hem. strep. infections (Surgical and non-surgical)	SA	SD	SA 4-6 SD 2-3	1 1	4 4	SA crystals	Reduce dosage after definite clinical response.
Severe staphylococcal infections. (Surgical and non-surgical) . . . . .	ST	SD	ST 4 SD 3	1 1-1.5	3 4	ST or SA crystals	Reduce dosage after definite clinical response. Continue half-doses until all foci have disappeared.
Gas bacillus infections . . . .	SD	ST	SD 3 ST 4	1-1.5 1	4 3	ST, SA or SD crystals Zinc peroxide	Wound must be widely opened—necrotic tissue excised. Use anti-gas serum I. V.
Peritonitis . . . . .	SA	SD	SA 4-6 SD 2	1.5 1	4 3	SA crystals	Intraperitoneal foci of origin must be surgically closed, drained or excised.

SA—Sulfanilamide

SD—Sulfadiazine

ST—Sulfathiazole

operatively. The main advantages of sulfanilamide for topical prophylaxis are its high solubility, its efficient diffusion, and its lack of interference with normal wound repair—properties in which sulfathiazole and sulfadiazine appear to be at a relative disadvantage. However, in the treatment of open infected wounds, the two latter drugs are more likely to be effective.

These kidney complications with sulfadiazine and sulfathiazole are due to the crystallization of the insoluble drugs and their acetyl derivatives in the upper and lower urinary tract. The best way of guarding against them is to administer sufficient fluid to maintain a daily urine output of over 1200 c.c. If this precaution is observed serious kidney complications



are rare. All of the drugs will occasionally produce skin reactions, drug fever, and mild or severe anemia, but if these effects are promptly recognized and dealt with they are not likely to endanger the life of the patient. The drug dosages outlined in Tables IV and V are for adult patients, and are calculated with due recognition of varying rates of excretion among the drugs and of the relative resistance to therapy of the infection under treatment. While frequent determinations of the drug concentration in the blood are helpful, in the avoidance of occasionally excessive levels and in deciding whether the drug dosage should be increased, the administration of sulfonamides should never be withheld simply because of the absence of laboratory facilities. The same applies to estimations of the hemoglobin and

blood cells. *However, a continuous record must be kept of the urine output of every patient receiving more than 4 grams per day of sulfathiazole or sulfadiazine, and every patient receiving any drug in the sulfonamide series in therapeutic doses should be carefully inspected by his physician at least once a day.*

#### SUMMARY

1. At least 50 per cent of the deaths in the last war from infectious diseases and from battle injuries would have been avoided if the sulfonamides had been available 25 years earlier.

2. During the present war great advantage may be taken of the effectiveness, ease of administration, and low toxicity of the sulfonamides.

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### BRITISH-AMERICAN AMBULANCE CORPS

The 600th American ambulance has been shipped abroad by the British-American Ambulance Corps of 420 Lexington Avenue, New York City.

This is the largest medical relief organization sending equipment to Britain and China. The ambulances cost from \$1300.00, for the light type used in industrial areas, to \$2000.00, for the equatorial type used in the deserts.

The British-American Ambulance Corps also

supplies mobile x-ray units and a motorcycle ambulance which is said to be the fastest life-saving machine in the world. It can travel at 90 miles an hour through terrain inaccessible to larger vehicles.

The American Medical Association is represented on the Chicago Committee of the British-American Ambulance Corps. This was announced recently by William V. C. Ruxton, President of the British-American Ambulance Corps.

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### AIR-RAID STRAIN

In 46 (15.3 per cent) of 300 consecutive admissions air-raids were given as a factor, but in only four (1.3 per cent) was this regarded as having a major influence, and in only six (2 per cent) as contributory. Of those in which air-raids appeared to be largely responsible for symptoms, two have recovered and

one is much improved. Of the six in which air-raids are thought to have been contributory, two have recovered and two have been discharged much improved. It is therefore not expected that there will be any burden on mental hospital beds as a result of raids.—I. Atkin, M D., *Lancet*, 1941. (Clinical Abstracts.)

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### WHAT IS THE AVERAGE LENGTH OF A GENERATION?

The question permits of different answers, according to the point of view. If we start with a cohort of 100,000 babies just born and trace them through life, we may regard these as one generation, and their average length of life, which according to present conditions is about 63 years, would then be the length of a generation. But generations of this kind overlap, because the replacement of each such gen-

eration by children begins while the generation is still in being, and the average interval from mother to daughter is about 28 years, from father to son about 33 years. This is what is usually thought and spoken of as the average length of a generation; in round numbers, there are thus three generations to the century.—From Statistical Bulletin of Metropolitan Life Insurance Co.

INTERSTITIAL KERATITIS \*

ELBERT S. SHERMAN, M.D., F.A.C.S., Newark, N. J.

Practically the only syphilitic disease of the cornea is interstitial keratitis, and in frequency it equals that of all other luetic diseases of the eye combined. It is nearly always a late manifestation of the hereditary form of the disease—only about three per cent of cases being caused by acquired syphilis. It occurs very rarely under five years of age or over forty. Holmes Spicer<sup>1</sup> published in 1924 a very complete study of nearly 700 cases of interstitial keratitis. In 67 per cent, the age of onset was between five and twenty years, and between twenty and thirty years in 23 per cent. Congenital syphilis was the cause in 90 per cent of the cases, the acquired form in 3.3 per cent and other causes in 6 per cent. These figures do not differ materially from those of other investigators.

To say anything before an audience of this kind about the clinical aspects of this disease is unnecessary. You are all familiar with them, and in fact not much has been added to the classic description by Sir Jonathan Hutchinson in his "Clinical Memoir of Certain Diseases of the Eye and Ear Consequent on Inherited Syphilis" published in 1863. The slit lamp and corneal microscope have served to increase our knowledge concerning some of the finer changes in the cornea, especially the permanent ones such as opacities and the remains of blood-vessels.

In the past there has been considerable difference of opinion concerning the reliability of the Wassermann reaction in interstitial keratitis. In a recently published study of syphilis in ophthalmology, Eric W. Assinder,<sup>2</sup> Visiting Pathologist to the Birmingham and Midland Eye Hospital, gives some interesting figures on this point. He says, "On looking through 100 consecutive cases of congenital syphilis with keratitis at my General Hospital Clinic, I found that 85 per cent gave a positive Was-

sermann reaction and 15 per cent were negative, but on further investigation I found that of those 15 per cent 14 had had previous anti-syphilitic treatment. The only patient who gave a negative Wassermann and had not been treated was a girl aged 20 with active interstitial keratitis of one eye whose mother gave a strongly positive Wassermann. According to my reckoning, the Wassermann reaction would thus be reliable in 99 per cent of the cases of syphilitic interstitial keratitis if we exclude the treated cases." He might have added that reports from different laboratories are not always the same. In the same report Assinder gives the following analysis of 1015 ophthalmic cases with positive Wassermann reactions.

WASSERMANN REACTIONS IN OPHTHALMIC CASES

ANALYSIS OF 1,015 POSITIVE CASES			
		Positive	Weakly Positive
1. Gumma in orbital area	.....	19	..
2. Scleritis	.....	17	..
3. Keratitis	.....	505	48
4. Iritis	.....	93	3
5. Choroiditis, retinitis	.....	72	15
6. Optic atrophy	.....	69	5
Optic neuritis	.....	12	7
7. Nerve palsies	.....	113	6
		—	—
		900	84
Miscellaneous	.....	31	..
		—	—
		931	84
Total	.....	1,015	

The same writer's figures show a steady decrease in the number of positive Wassermann results during the past 15 years—the positive cases in 1940 being less than one-third the figure reached in 1927.

Those of us who have been in practice during the past 20 years have noted the marked decrease in the incidence of syphilitic diseases. The causes are well known. An important factor in the decrease of the number of cases of interstitial keratitis as well as other forms of hereditary syphilis is the routine Wassermann test for all expectant mothers. The results of this should be increasingly noticeable in the

\* Presented before the Section on Eye, Ear, Nose and Throat at the Annual Meeting of The Medical Society of New Jersey, April 22, 1942.  
1. Spicer: Brit. Jour. of Ophthal. 1924. Monograph supplement.  
2. Assinder: Brit. Jour. of Ophthal. Jan., 1942.

future. The comparatively recent enactment requiring a pre-marital Wassermann test should also produce favorable results.

Nearly all writers agree that an injury of the eye of a person with a positive Wassermann may be the inciting cause of an attack of interstitial keratitis. The injury may be very trivial, such as a small abrasion or a foreign body in the cornea. It has occurred in soldiers following a gas attack. The second eye is nearly always subsequently attacked as it is in nontraumatic cases. This is of great importance in claims under the Workmen's Compensation Act because the employer or his insurance carrier is held responsible for the treatment and disability of both eyes.

I have had two of these cases. The more recent one was a man 23 years old with Hutchinson's teeth and a positive Wassermann. Three days before he was sent to me a small foreign body had become embedded in the cornea of the right eye. This had been removed. The eye was slightly red and there was a faint, deep haze in the lower half of the cornea. This progressed rapidly and four days later there was a typical interstitial keratitis which soon involved the whole cornea accompanied by a severe anterior uveitis. Two weeks after the date of the injury the cornea of the left became hazy.

The progress in this eye was similar to that in the injured eye. The iritis was so severe that it was difficult to keep the pupil dilated, even with repeated subconjunctival injections of atropine and adrenalin. In the meantime the patient was having constant anti-syphilitic treatment in a venereal disease clinic. The uveitis was active for more than six months. In this case the insurance carrier assumed the entire responsibility for both eyes.

The prognosis of interstitial keratitis, considering the density of the opacities in the cornea and the deeper inflammatory changes, is surprisingly good. According to Duke-Elder,<sup>3</sup> about 70 per cent get a final visual acuity of 20/20 to 20/50 and in only about 10 per cent is it less than 20/200. H. Hoehne,<sup>4</sup> in a recent paper based on a study of 162 patients, says

that 15 per cent failed to recover with sufficient vision for most occupations. Probably because of a thinning or weakening of the corneal structure myopia is a rather frequent sequel. This occurred in one of my earliest cases, a boy of twelve years who developed four diopters of myopia following a bilateral attack, although his final corrected vision was 20/20 in each eye. Hirschberg<sup>7</sup> mentioned this cause of myopia in his monograph published in 1912.

When beginning the treatment of a case of interstitial keratitis the patient should be informed concerning the long course of the disease and of the probability of later involvement of the second eye. As there is always more or less anterior uveitis, atropine should be used immediately and continued as long as there is any redness. Concerning the value of specific treatment and also of the relative values of mercury and the arsenicals, writers are of various opinions. Hoehne<sup>4</sup> says that specific treatment is of little or no value. Duke-Elder<sup>3</sup> says: "No substantial progress has been made since Hutchinson's day, and little or nothing can be done to alter the course of the disease or shorten the duration." He also says: "General treatment should be directed to the syphilitic infection, not because it makes much difference to the local disease, but because further syphilitic developments may thereby be prevented." Contrary, or at least less conservative views, are held by many others. Sandford Gifford<sup>5</sup> says that most clinicians are agreed that some sort of specific treatment is indicated, and advocates the use of arsenicals with the use of mercury by inunction at the same time. Assinder is very definite and emphatic in recommending the immediate and prolonged use of arsenicals and bismuth. He believes "without a shadow of a doubt that these cases do infinitely better when they are used than without their use" and asserts that only one eye was affected in 43 per cent of his cases. He also strongly opposes the use of hot applications, claiming it prolongs the florid stage of the disease.

For certain cases that are not doing well

3. Duke-Elder: *Text-book of Ophthalmology*. Vol. ii, p. 1976.

4. Hoehne: *Klin, Monatsbl f. Augenh.* 105:656, 1940.

5. Gifford: *Ocular Therapeutics*. 3rd ed., p. 270.

7. Hirschberg: *Treatment of Short-sight*. Monograph, 1912.



under specific treatment the addition of foreign protein injections has been recommended<sup>6</sup> and is said to have acted favorably.

After the acute symptoms have subsided, Gifford advocates the use of dionin and yellow oxide of mercury ointment to promote clearing of the opacities. Duke-Elder says such treatment is "for the most part useless". Having often used these remedies for this and other types of corneal opacities, I have never been convinced that they were helpful. During the past few years I have seen only a very few cases of interstitial keratitis and have no definite opinion concerning some of the controversial matters just mentioned. However, of

one thing I am sure: that treatment of the patient is as important as treatment of the eye. This is sometimes overlooked. These patients, especially children, are often undernourished, weak and anaemic. Everything possible should be done to build up the general health—good food, vitamins, fresh air and sunshine. They should be fitted with sun goggles and kept out of doors as much as possible. Specific treatment is more effective in any form of syphilis if iron is given. Years ago I had some very satisfactory results from mercurial inunctions. This form of treatment is probably as effective as ever, but nowadays it seems that unless a remedy is injected with a needle it is not very popular.

671 Broad Street

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## GRANT FOR THE STUDY OF INFANTILE PARALYSIS

Announcement of a five-year, \$300,000 grant by the National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York, N. Y., to The Johns Hopkins University, Baltimore, for an intensive and long-time study of the disease of infantile paralysis was made recently by Basil O'Connor, President of the National Foundation for Infantile Paralysis.

This is the largest single grant made by the National Foundation since it was organized in 1938. It will be used to establish and conduct the Center for the Study of Infantile Paralysis and Related Viruses at the Hopkins. Epidemiologists, virologists, serologists, neurologists and chemists acquainted with the problems presented by poliomyelitis are available there.

"In view of war conditions it is highly desirable, if it can be accomplished without sacrificing defense interests, to keep a nucleus of scientists at work on the problems of infantile paralysis which are so important to human welfare, with the hope that, when peace is

established, contemplated expansion in this field may be rapidly consummated."

Work at the Center will be under the direction of Dr. Kenneth F. Maxcy, professor of epidemiology in the School of Hygiene and Public Health. Dr. Maxcy will be assisted by a competent group of scientists, some of whom already have made significant contributions to research in this field.

In setting up the Center, adequate laboratory space and facilities have been provided and resources of the new grant will permit the investigators to carry on their studies in the field as well as in the laboratory as opportunity may be presented. The ultimate objective is to gain a more complete understanding of the spread of the poliomyelitis virus not only within the human body, but in the community, from one individual to another. The mechanism by which it maintains itself in human populations is not yet known. Much additional knowledge is necessary before it will be possible to devise effective measures for the suppression of the disease.

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## DIATHERMY AND VASODILATATION

Short-wave diathermy applied to the trunk of the human body is a safe and efficient means of producing peripheral vasodilation of the lower extremities and, as such, should be of value in the management and study of peripheral vascular disease. The use of the electro-

magnetic cable in a pancake formation under the lumbosacral region was found to be simpler in application and more comfortable in use than were several other possible applications of electrodes, and as efficient in operation as any of the other possible applications.—R. L. Bennett et al., in *Amer. Heart Journ. (Clin. Abstracts, 1941.)*

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6. Marchesani: *Arch. f. Augenh.* 99, 207, 1928.

## THE DIAGNOSIS OF GALL-BLADDER DISEASE \*

By LOUIS L. PERKEL, M.D., F.A.C.P., Attending Gastro-Enterologist,  
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Gall-bladder disease is the commonest organic cause of gastro-intestinal symptoms. Although it is popularly associated with women who are "fair, fat and forty", it occurs in men as well as women, in the lean and the obese, and in youth as well as in old age. It is much more prevalent in women, however, than in men.

### INCIDENCE

In a recently studied series of 400 surgically treated gall-bladder patients on the service of Dr. Edgar Burke at the Jersey City Medical Center (Table 1), there were 312 females and 88 males, a ratio of  $3\frac{1}{2}$  to 1. The youngest patient was 17 and the oldest, 83 years. The average age was 42. Fifty-one, or 11.7 per cent, were under the age of 30, while 75 per cent were between 30 and 60. Of all the decades, the fifth showed the highest frequency, namely 134 cases or 33.5 per cent. The group of greatest incidence is that of stout, middle-aged women who have had one or more pregnancies.

Although there is no proof that heredity plays a definite rôle in the etiology of gall-bladder disease, it is well known that biliary tract affections occur with unusually high frequency in certain families showing a predisposition to obesity and diabetes.

The factors to be considered in the diagnosis of gall-bladder disease are the history, physical examination, laboratory data, biliary drainage studies and roentgen findings. In spite of the constantly improved and increased use of the latter objective methods, a carefully taken and judiciously evaluated case history is still of primary importance in formulating a diagnosis of gall-bladder pathology.

### GALL STONE COLIC

An attack of gall stone colic is usually typical enough to be readily diagnosed. The patient

is suddenly seized with a severe, agonizing pain in the right upper quadrant or epigastrium and occasionally in the left upper quadrant. The pain may radiate along the right costal margin to the back or to the right shoulder. Frequently, the patient's apprehension is heightened by her apparent inability to breathe, due to reflex fixation of the diaphragm. The attack often occurs at night or during the early morning hours and characteristically requires hypodermic administration of morphin or its derivatives for relief.

There may be mild or severe nausea and vomiting. Residual soreness in the epigastrium or right upper quadrant may persist for hours or days, depending upon the degree of associated inflammation of the gall-bladder. Similarly, slight or moderate fever together with a corresponding leukocytosis may be present, although usually the temperature and leukocyte count are normal. Jaundice is manifested only if the common duct is occluded or if cholangitis ensues.

### ACUTE CHOLECYSTITIS

Acute cholecystitis in most instances represents an acute exacerbation of a chronic cholecystitis. If there is an associated gall-stone colic the findings are as outlined for the latter, superimposed by symptoms and signs of infection. With or without stones, there are present, in varying degrees, upper abdominal pain, localized tenderness and muscle spasm in the right upper quadrant, fever, leukocytosis and occasionally jaundice. A distended, tender gall-bladder and swollen liver may be palpable.

In over three-quarters of the cases, the acute attack subsides in a few days. On the other hand, as is indicated by persistence and aggravation of the symptoms and signs, the inflammatory process may progress to empyema, gangrene or perforation of the gall-bladder, peritonitis, or cholangitis.

It is therefore mandatory that in every case of acute cholecystitis constant observations be

\* Read before the Section on Gastro-Enterology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 22nd, 1942.

made of temperature, pulse, leukocyte count, abdominal signs and symptoms and clinical and laboratory evidences of icterus. Because of the possible development of the aforementioned complications, which are amenable only to prompt surgical treatment, all patients should be hospitalized and a surgeon should be constantly available for consultation from the time of the patient's admission to the hospital.

Among the conditions simulating acute cholecystitis are acute perforated peptic ulcer, acute pancreatitis, pyelitis and pyonephrosis. Acute appendicitis, particularly with a high placement of the appendix, may be mistaken for cholecystitis. Coronary occlusion can simulate an attack of acute cholecystitis as both may be manifested by severe upper abdominal pain, nausea, vomiting, fever and leukocytosis. The differential diagnosis may present some difficulty, particularly during the first few hours of the attack. In the case of coronary occlusion, sudden shock with fall in blood pressure, a characteristic electrocardiogram and sometimes a pericardial friction rub are the common findings, while the localized tenderness and rigidity in the right upper quadrant seen in acute cholecystitis are rarely present.

As coronary heart disease and chronic cholecystitis may co-exist, the determination of which is the cause of an acute attack in any given case often presents a diagnostic problem. Added to this difficulty is the well-known fact that gall-bladder dysfunction may produce cardiac arrhythmia and even electrocardiographic changes characteristic of coronary disease. Proof of this causal relationship is furnished by occasional instances in which relief from the cardiac symptoms and return to normal of the electrocardiographic findings followed cholecystectomy.

#### CHRONIC CHOLECYSTITIS

The diagnosis of chronic cholecystitis from the history alone is not as simple as that of the acute form. Some patients harboring a pathological gall-bladder complain of no pathognomonic symptoms. They appear in good health, complaining only of such vague disturbances as nervousness, undue fatigue, insomnia, headache and indefinite joint and mus-

cle pains—a syndrome often labeled neurasthenia. Others complain of recurring or persistent dyspepsia, with or without a past history of attacks of biliary colic or of acute cholecystitis. The dyspeptic symptoms are numerous, including heartburn and variously described upper abdominal distress during or soon after eating.

Gaseous indigestion, manifested by belching and a sensation of fullness or distention after a few mouthfuls of food, is the most frequent complaint. These symptoms are the result of reflex irritation of the stomach, causing gastric hypertonicity, hyperperistalsis and pylorospasm.

In some patients the distress occurs several hours after eating and may be partly relieved by the taking of soda or by the eructation that usually follows. There is lacking, however, the complete relief by food and the clock-like recurrence of pain characteristic of duodenal ulcer. Occasionally the latter is a concomitant lesion.

The low-grade infection frequently present produces the general malaise, headaches, achiness and fatigue. This is aggravated by the nutritional deficiency resulting from the patient's *fear* of eating. Self-imposed or unwisely prescribed dietary restrictions accentuate this picture of malnutrition, occasionally arousing an unfounded suspicion of malignancy.

Constipation is a prominent symptom, probably the result of the progressive curtailment of food intake and the commonly associated spastic colon. Diarrhea is occasionally present and may be of the gastrogenous type due to the achylia so frequently found in gall-bladder disease. The so-called qualitative or selective dyspepsia, that is, intolerance to fats and roughage, is a striking symptom in many cases but is not always present.

#### PHYSICAL EXAMINATION

Physical findings in the abdomen may be entirely negative. On the other hand, there may be definite tenderness on palpation of the gall-bladder region and occasionally of the epigastrium. In hydrops or empyema the enlarged gall-bladder can usually be palpated, un-



less the obesity so frequently present makes a satisfactory examination difficult or even impossible. The habitus of the patient must be considered in attempting to outline the gall-bladder or to locate tender points, as, in the visceroptotic, the gall-bladder, in common with the other abdominal organs, is situated low.

The general physical examination should extend beyond the abdomen to exclude extra-biliary conditions known to mimic gall-bladder disease. Especially to be ruled out are such pain-producing lesions as herpes zoster, gastric crises, spinal arthritis and metastases from malignancy of the prostate or female pelvic organs.

#### LABORATORY FINDINGS

The laboratory studies in every case of suspected cholecystic disease should include routine urinalysis, blood count and the Wassermann test of the blood. Thus, certain extrinsic conditions as urological disease, diabetes and lues are excluded. Gastric analysis may show a normal acidity but more often there is low or absent hydrochloric acid. Occasionally, hyperacidity is present. The subacidity or anacidity universally associated with cholecystic disease may, in fact, represent the normal depression of acid secretion in middle age or beyond, the period of greatest incidence of gall-bladder disease.

Although clinical jaundice may be present during acute attacks, due to calculous obstruction, cholangitis or hepatitis, it is rarely seen in the intervals between attacks, except in common duct obstruction. If latent jaundice is suspected, its presence is determined by the icteric index and the quantitative Van den Bergh tests of the blood.

#### BILIARY DRAINAGE

Biliary drainage, popularized by Lyon, whose name the procedure bears, is believed by some to be the most precise method of diagnosing cholecystic disease. The procedure consists of intubation of the duodenum, preferably under fluoroscopic control, and the instillation of magnesium sulphate solution. The latter causes relaxation of the sphincter of Oddi, thus inducing emptying of the gall-bladder. The

bile thereby obtained is examined grossly, microscopically and bacteriologically. The dark or "B" bile which most authorities believe comes from the gall-bladder is the fraction measured and examined for cholesterol crystals, calcium bilirubinate pigment, leukocytes and bacteria. Absence or a trace of "B" bile on repeated examinations is considered a sign of gall-bladder pathology. The finding of crystals or pigment clumps indicates the presence of calculi. The presence of pus or bacteria is considered pathognomonic of infection. The absence of these elements, however, does not necessarily exclude pathology.

It is obvious that biliary drainage can attain a high degree of accuracy only at the hands of competent, experienced workers exercising meticulous technique and discerning judgment in the interpretation of the findings.

#### CHOLECYSTOGRAPHY

Cholecystography is acknowledged by all to be the most valuable diagnostic aid in cholecystic disease. Prior to the introduction of this epoch-making test by Graham in 1924, the roentgen diagnosis was limited to the detection of opaque calculi and calcified gall-bladders. Occasionally a thick-walled gall-bladder would be faintly visualized on a primary or scout film. Considerable help was also derived from the secondary or indirect roentgen findings elicited from the gastro-intestinal series with barium. These are pylorospasm, spasm of the antrum or of the duodenal bulb, irregularity of the bulb due to peri-duodenal adhesions, and fixation of the duodenum or of the hepatic flexure by adhesions. These findings, though not strictly pathognomonic, are still valuable signs supplementing the clinical and cholecystographic data.

With the aid of the halogen dye, sodium tetraiodophenolphthalein, commonly administered orally, the bile in the normally functioning gall-bladder is rendered opaque, resulting in a well-visualized gall-bladder shadow of good, homogeneous density and regular contour. Besides its demonstration of the concentrating function of the gall-bladder, cholecystography also serves as a test of the gall-bladder's ability to contract and empty on stimula-

tion of a fatty meal. It also reveals anatomical abnormalities caused by peri-cholecystic adhesions and fibrotic changes secondary to cholecystic inflammation.

The cholecystographic criteria of pathology are faint or no visualization of the gall-bladder, cholelithiasis, and distortion of the gall-bladder outline. Faint visualization indicates an impairment of the gall-bladder's concentrating ability, while non-visualization or no shadow, represents a non-functioning gall-bladder. Non-visualization is usually caused by cystic duct obstruction, most often by stones. It may also result from chronic cholecystitis, abnormally thickened wall, viscid bile or complete packing of the gall-bladder with stones.

Because of the many possible sources of error, these findings must be judged with extreme caution. It cannot be too strongly emphasized that proper preparation of the patient and carefully standardized technique in gall-bladder roentgenography are essential prerequisites for accurate interpretation. In evaluating a faint or absent shadow one must be certain that there is no liver dysfunction such as in hepatitis or cirrhosis, and that the patient has received a sufficient amount of the dye with adequate absorption in the intestinal tract. The examiner should make sure, by careful questioning of the patient, that the dye has not been lost by vomiting or diarrhea. Pyloric obstruction and even spastic colon may at times prevent a normal gall-bladder from accepting the dye and thus lead to false interpretation. Should there be any doubt as to the validity of the cholecystographic findings, the examination should be repeated at a suitable interval, and, if deemed necessary, with the dye administered intravenously.

Opaque or calcium stones are seen as single or multiple positive shadows, sometimes with concentric rings due to laminations. Occasionally there is sufficient concentration of the dye to obscure small, faintly opaque stones which would have been visualized on a primary or scout film, taken before the dye is given. Among the simulants of opaque gall stones are calcified costal cartilages, renal calculi, calcified lymph nodes and opaque material in the bowel.

Non-opaque or cholesterol stones are seen as

negative shadows in a dye-filled gall-bladder. They may be small or large, single or multiple, and frequently produce a leopard skin or mottled design in the gall-bladder shadow. Obviously their detection is possible only when the gall-bladder accepts sufficient dye to act as a background for the delineation of the negative shadows. Because of this, an appreciable number of non-visualized gall-bladders showing no direct roentgen signs of calculi, are found, at operation, to contain non-opaque stones. A frequent and annoying source of error in the interpretation of negative shadows is the presence of gas in the small or large intestine. These small bubble-like collections of gas may overlap the gall-bladder shadow and be mistaken for non-opaque stones. The use of enemas, Pitressin, and the taking of films in oblique positions are some of the methods employed in an attempt to eliminate this disturbing factor.

In a series of 300 surgically treated gall-bladder patients at the Jersey City Medical Center (Table 2) a comparison was made of the cholecystographic and operative findings in order to determine the diagnostic reliability of the former. In the 242 cases in which pathological gall-bladders with stones were found at operation, the cholecystograms showed the same in 159 cases (65 per cent), pathological gall-bladders with no direct signs of stones in 80 cases (33 per cent) and apparently normal gall-bladders in three cases (1.2 per cent). In the 58 cases in which pathological gall-bladders without stones were found at operation, the cholecystograms showed the same in 46 cases (79 per cent), suspicion of stones in six cases (10 per cent) and apparently normal gall-bladders in six cases (10 per cent). Recapitulation shows a gross error in diagnosis in 15 cases (5 per cent). On the other hand, the total number correctly diagnosed as pathological by cholecystography was 291 cases or 97 per cent of the 300 cases found at operation to have pathological gall-bladders with or without stones.

#### DIFFERENTIAL DIAGNOSIS

Numerous pathological conditions may, at times, simulate chronic cholecystitis. The most

common of these are peptic ulcer; duodenal stasis; appendiceal pathology; carcinoma of the stomach, pancreas, liver or colon; spastic colon; renal pathology and hepatic cirrhosis. Usually, however, the characteristic clinical, laboratory and roentgen findings in these extrinsic conditions are easily elicited and differential diagnosis should not be difficult. Occasionally in cardiac decompensation the dyspeptic symptoms and abdominal signs due to passive congestion of the stomach and liver may superficially resemble those of cholecystic disease, but here the cardiac etiology is present.

## SUMMARY

1. Gall-bladder disease is the commonest organic cause of gastro-intestinal symptoms in adults. Although it may occur in both sexes, at all ages, and in all types of body habitus, its greatest incidence is in middle-aged, stout, multiparous women.

2. Attacks of biliary colic and acute cholecystitis are in most instances readily diagnosed by their typical clinical findings.

3. Chronic cholecystitis presents a varied symptomatology which may resemble that of many other conditions from neurasthenia to gastro-intestinal malignancy. The syndrome of gaseous indigestion is characteristically present in most cases. A past history of acute attacks strongly supports the diagnosis.

4. Biliary drainage is a very useful diagnostic measure in the hands of skilled and experienced workers, exercising critical judgment in the interpretation of the findings.

5. Cholecystography is the most valuable single diagnostic test yielding the highest percentage of accuracy, provided extreme care is used in the preparation of the patient, roentgenographic technique and interpretation guarded by the recognition and elimination of the many sources of error.

6. The optimal degree of accuracy in the diagnosis of gall-bladder disease is best attained by the correlation and careful evalua-

tion of all the findings derived from the clinical, laboratory, biliary drainage and roentgen examinations.

TABLE 1

## BILIARY TRACT OPERATIONS

(Service of Dr. Edgar Burke)

JERSEY CITY MEDICAL CENTER

## AGE AND SEX DISTRIBUTION

	No. of Cases	Per Cent
Total number of cases in series . . .	400	100
Females . . . . .	312	78
Males . . . . .	88	22
Age:		
Under 20 (youngest—17) . . . . .	4	1.0
21 to 30 . . . . .	47	11.7
31 to 40 . . . . .	96	24.0
41 to 50 . . . . .	134	33.5
51 to 60 . . . . .	85	21.2
61 to 70 . . . . .	25	6.2
71 and over (oldest—83) . . . . .	9	2.2
Average age—42		

TABLE 2

## COMPARISON OF CHOLECYSTOGRAPHIC AND OPERATIVE FINDINGS

Findings	No. of Cases	Per Cent
Total number of cases in this series	300	100
Operative:		
Pathological gall-bladder with stones . . . . .	242	80.6
Cholecystographic:		
Pathological gall-bladder with stones . . . . .	159	65.0
Pathological gall-bladder, stones not shown . . . . .	80	33.0
Normal Gall-bladder . . . . .	3	1.2
Operative:		
Pathological gall-bladder, no stones	58	19.3
Cholecystographic:		
Pathological gall-bladder (Faint or no shadow) . . . . .	46	79.0
Pathological gall-bladder (and suspicion of stones) . . . . .	6	10.0
Normal gall-bladder . . . . .	6	10.0
Error in cholecystographic diagnosis	15	5.0
Total number diagnosed by cholecystography as pathological, in 300 cases found at operation to be pathological, with and without stones . . . . .	291	97.0



## DISCUSSION

By S. BERNARD KAPLAN, M.D., Newark, N. J.

Dr. Perkel has given us such a carefully tabulated analysis of the diagnostic problems of gall-bladder disease that it is rather difficult to add anything thereto. Yet with a disease which comprises almost half of the admissions of the organic diseases that enter our clinics today, there must be room for some discussion of this vital subject.

I wish to inquire of Dr. Perkel as to his experiences in the acute types of gall-bladder cases. In perusing our clinic records I note that we see just about as many males as females in those cases which develop an acute cholecystitis. This in direct contrast to the chronic cases.

In a recent paper on this problem of gall-bladder I advanced the opinion that diet played the most important part in the etiology of gall-bladder disease and heredity merely an incidence. A family brought up on the same foods over long periods of time, together with the extreme methods of living today, nervous tension and our highly premasticated foods contribute to a delay in gall-bladder emptying with resultant stasis.

In Dr. Perkel's paper he has listed among other things, dyspepsia as a diagnostic complaint in gall-bladder disease. I wonder if there is a dyspepsia due to gall-bladder disease? Past experiences have shown that innumerable patients with this com-

plaint have returned after cholecystectomy with the same dyspeptic complaints. We have found the same dyspepsias with unstable colons, even to the fat and carbohydrate intolerances. No patient should be told that his dyspeptic symptoms will be cleared by surgical removal of the gall-bladder. I would be interested in knowing from Dr. Perkel how he has fared with his cholecystectomized patients, in their return to his clinics and office with the self-same complaints as previous to the operation. I know many of my colleagues have conveyed to me that many of their patients do return. I wonder how many of their service have returned for treatment of the same symptom.

We therefore, as gastroenterologists, should try to avoid the unnecessary pitfalls of unsuccessful operations by following Dr. Perkel's splendid outline of the diagnosis of gall-bladder conditions.

Dr. Perkel's percentage of good results speak only of the amazing individual detail and accuracy in handling these cases.

I believe the inadequacy of the medical diagnosis and manager of gall-bladder disease accounts for the intrusion and dominance today of surgery.

It is always a pleasure and privilege to discuss the excellent papers of Dr. Perkel and especially on a subject in which we are exceptionally interested.

## A BETTER TECHNIC IN OPERATING FOR APPENDICITIS

Babcock discusses improved operative and post-operative technics for the reduction of death and disability in appendicitis. Because of the peritoneal reaction of conventional drains, he strongly advocates the use of small, double suction drains of glass or rustless steel.

The advantage of annealed alloy stell wire for suturing is set forth. A short, muscle-splitting incision is advocated, and other steps in operative technic are described in detail.—W. W. Babcock, J. Intern., Coll. Surgeons, 1941 (Clinical Abstracts).

## FRACTURE OF THE NECK OF THE FEMUR: RAPID NAILING

To localize the head of the femur a coin is fixed to the skin and a roentgenogram is made after centering the x-ray tube with a plumb line over the coin. This gives a positive relative position for directing the nail toward the head of the bone.

To secure the proper lateral position of the nail, internally rotate the thigh to a point when tension is placed on the posterior structures of the hip joint. This brings the neck of the femur more nearly parallel to the operating table.

The film tunnel which the author uses is made of rigid material and is placed on the ordinary operating table.

If the nail is properly placed on the first attempt, which it usually is, the entire procedure under anaesthetic takes but a few minutes.

The anaesthetic of choice is Pentathol Sodium.—A. D. Laferte, Journ. Mich. Med. Society, 1941.

**SPONTANEOUS SUBARACHNOID HEMORRHAGE \*****AN ANALYSIS OF FIFTY CASES**

By B. A. HIRSCHFIELD, M.D., Trenton; A. S. TORNAY, M.D., Philadelphia, and  
J. C. YASKIN, M.D., Philadelphia

From the Department of Neurology, Graduate School of Medicine, University of Pennsylvania, and the  
Medical Department, St. Francis Hospital, Trenton.

It is desirable that the clinician be keenly aware of and early detect meningeal irritation arising from any of its various causes, just as he has become thoroughly familiar with the problem of the acute abdomen. Among the causes of meningeal irritation, spontaneous subarachnoid hemorrhage is a relatively common one, frequently overlooked and is, indeed, not even recognized by some examiners as a distinct clinical entity. This fact is unfortunate as its recognition is important both for prognostic and for therapeutic purposes. One of us, practicing in a city of 125,000, has seen 21 instances of this condition occur within a period of three years, demonstrating its comparative frequency. As the symptoms are sometimes referable to bodily systems other than the nervous system, it is likely that in many cases the proper diagnosis is not suspected and the spinal fluid is not examined. It is our belief that many cases are thus missed.

This presentation is based on an analysis of 50 cases, 21 of which were observed at St. Francis Hospital in Trenton within the last three years and 29 at the Graduate Hospital in Philadelphia in a similar period.

**DEFINITION**

The term spontaneous subarachnoid hemorrhage refers to the sudden outpouring or leakage of blood into the subarachnoid space, caused by rupture of an aneurysm, or an otherwise abnormal blood vessel, of the circle of Willis or its extracerebral branches. The term does not include those cases of blood in the subarachnoid space resulting from extension of massive intracerebral hemorrhage, intraventricular hemorrhage, the bleeding produced by trauma with laceration of blood vessels and brain tissue, hemorrhage from a brain tumor, hemophilia, essential thrombocytopenia, or hemorrhagic encephalitis.

**PATHOLOGY AND ETIOLOGY**

The rupture of a diseased blood vessel is the immediate cause of spontaneous subarachnoid hemorrhage. Most investigators regard aneurysm of an artery of the arterial circle of Willis or its branches as the most important vascular lesion. Such aneurysms may be due to a congenital defect of the muscular coat of the artery, as described by Eppinger in 1887.<sup>1</sup> Aneurysms also form as the result of atherosclerotic changes in these arteries, with resultant weakening and bulging of the vessel wall. However, rupture of the atherosclerotic artery may also occur without actual aneurysmal formation (Bagley<sup>2</sup>). In addition, mycotic aneurysms in this location are described as due to lodgment of an infective embolus, most commonly from the vegetations of bacterial endocarditis, with consequent infarction and destruction of the tunica media and aneurysmal bulging. Syphilis as a factor seems to be insignificant.

The disease is more common in the male than in the female. In our series there were 31 males and 19 females.

The ages varied from eight to 71 years, but as seen in Table I, most of the cases (37 out of 50) occurred between the ages of 30 and 60 (70 per cent) in both sexes.

**TABLE I.****AGE AND SEX INCIDENCE IN SPONTANEOUS  
SUBARACHNOID HEMORRHAGE**

Age	Male	Female	Total
Under 10 .....	1	0	1
10-20 .....	3	0	3
20-30 .....	1	3	4
30-40 .....	6	2	8
40-50 .....	9	8	17
50-60 .....	6	6	12
60-70 .....	4	0	4
70-80 .....	1	0	1
Totals .....	31	19	50

\* Read before the Section on Medicine, Annual Meeting of The Medical Society of New Jersey, Atlantic City, April 22, 1942.

1. Eppinger, H.; Arch. f. klin. Chir., 1887, 35:1-553.  
2. Bagley, C., Jr.: Arch. Neurol. & Psychiat., 1932, 27: 1133-1174.

The precipitating factors are often unknown. Some cases result from emotional strain, others from severe physical exertion such as lifting, and some follow coitus.

#### ASSOCIATION WITH HYPERTENSION

The association of spontaneous subarachnoid hemorrhage with hypertension has not been sufficiently emphasized. In this series of 50 cases, 33 or 66 per cent gave the definite history and findings of high blood pressure. Table II shows the incidence of hypertension in relation to age and sex. As may be seen, many of these are comparatively young individuals, in whom it may easily be presumed that the abnormal blood pressure caused the "blowout" of a congenital aneurysm; or, if the hypertension had existed long enough to have produced vascular disease, the rupture may have occurred in an atherosclerotic vessel. In the older patients with high blood pressure, it is logical to suppose that the hypertensive disease had led to atherosclerotic changes in the vessels at the base of the brain with or without aneurysmal formation.

TABLE II.

CASES IN SERIES EXHIBITING HYPERTENSION IN  
SUBARACHNOID HEMORRHAGE (66%)

Age	Male	Female	Total
Under 10	0	0	0
10-20	2	0	2
20-30	1	0	1
30-40	5	1	6
40-50	4	4	8
50-60	6	6	12
60-70	4	0	4
70-80	0	0	0
Totals	22	11	33

#### SYMPTOMATOLOGY

Spontaneous subarachnoid hemorrhage gives rise to a rather uniform set of symptoms and signs, the severity of the picture varying according to the amount and the persistence of the bleeding. The onset is abrupt, as is characteristic of cerebral hemorrhage in general. The patient is suddenly stricken with a severe pain in the head, most frequently in the suboccipital region. Following this, there is some degree of impairment of consciousness ranging from haziness of vision or confusion to complete

coma. Sometimes there are convulsions. Almost always there are nausea and vomiting, which tend to persist for hours. Later, the temperature rises commonly to 100° F. to 103° F. The pulse rate corresponds to the temperature, except in cases where the hemorrhage is severe enough to cause medullary compression when bradycardia develops. Laboratory studies show a moderate to a high leukocytosis constantly, albuminuria frequently and glycosuria at times.

On examination, there may be found a patient who is complaining of intense headache, nausea and vomiting; or, there may be found a patient in delirium or coma. Within 24 hours, if looked for, there are always manifestations of meningeal irritation: stiff neck and Kernig signs. Photophobia is usual, when the patient can complain. Generally, the tendon reflexes are absent or difficult to elicit; Babinski signs, however, are frequently found. Focal neurologic signs are not uncommonly present. They may be transient and variable. Among these signs are such cranial nerve disturbances as oculomotor palsies, inequalities of the pupils, pain in the distribution of the trigeminal nerve (especially the ophthalmic division), facial weakness and, rarely, deafness. Also, there may be hemiplegia, usually only partial or slight, and aphasia. Papilledema may be seen in varying degrees.

The examination of the spinal fluid, of course, confirms the diagnosis of subarachnoid bleeding. The fluid is frankly bloody in the beginning, becoming xanthochromic after a week and later watery clear again, unless another hemorrhage supervenes. The blood is well mixed and does not clot. The pressure is, at the outset, nearly always elevated, decreasing with the appearance of the xanthochromic fluid.

In summary, with a history of sudden pain in the head occurring in a patient, who may have been previously well, followed by nausea, vomiting, impairment of consciousness and signs of meningeal irritation, the presence of spontaneous subarachnoid bleeding should be considered as likely. A lumbar tap, then performed, will corroborate the diagnosis if the characteristic bloody fluid is obtained.



COURSE

In the majority of cases improvement, both subjective and objective, sets in before the end of the first week. Consciousness becomes gradually clearer, headache and dizziness become less severe, and the vomiting less frequent. Signs of meningeal irritation persist for two weeks or longer, even in the very favorable cases and often in spite of the fact that the spinal fluid becomes clearer. The temperature generally drops before the end of the first week. In some cases mental confusion may persist for several weeks. The majority of cases recover in from three to four weeks and with relatively few residual symptoms. Among the residual symptoms may be mentioned headache, dizziness, fatigability and irritability.

In the fatal cases there is usually a deepening of the stupor with respiratory complications and eventually medullary failure. Some patients, apparently recovering, develop other hemorrhages to which they usually succumb.

DIFFERENTIAL DIAGNOSIS

Spontaneous subarachnoid hemorrhage is to be differentiated from intracerebral hemorrhage and hemorrhage into the subarachnoid space from a bleeding tumor of the brain as in these conditions the onset may likewise be sudden and severe. Meningitis and meningoencephalitis, and the disorders giving rise to coma in general, also come into consideration. All these conditions are differentiated by a study of history, by the presence or absence of signs of chronically increased intracranial pressure and signs of focal brain disease, and by the further course of the process.

PROGNOSIS

The prognosis of this stormy disease is better than is generally supposed. In this series there were 22 deaths of the 50 cases (44 per cent), which corresponds to the rate obtained by other observers.<sup>3,4</sup>

The presence of hypertension increases the gravity of the outcome, as shown in this series, in which 15 of the 22 fatal cases (68 per cent) had this complication. (See Table III.)

The recurrence of hemorrhage during the course or soon after recovery, usually results in fatality. Hemorrhages occurring months or years after the primary attack may not be so serious. In this series there were eight patients who had had more than one attack. Four of these died.

TABLE III.

AGE AND SEX INCIDENCE IN THE 22 FATAL CASES OF SPONTANEOUS SUBARACHNOID HEMORRHAGE

Age	Male	Female	Total
Under 10 .....	0	0	0
10-20 .....	2	0	2
20-30 .....	1	0	1
30-40 .....	3	1	4
40-50 .....	5	2	7
50-60 .....	2	3	5
60-70 .....	2	0	2
70-80 .....	1	0	1
Totals .....	16	6	22

Fifteen or 68% of the fatal cases were hypertensive.

TREATMENT

At present, there is no direct method of stopping spontaneous subarachnoid hemorrhage, but natural clotting may be facilitated by keeping the patient quiet by the use of sedatives, such as morphine, phenobarbital and salicylates.

Spinal puncture is an important adjunct in the treatment, having for its objects (1) the withdrawal of irritating bloody spinal fluid, thus diminishing meningeal irritation, hastening recovery, and, perhaps, preventing arachnoiditis; (2) controlling increased intracranial pressure. Needless to state, the lumbar tap must be performed only with complete manometric control, the fluid should be allowed to escape slowly and the pressure should not be reduced as low as normal (8 to 11 mm. of mercury or 120 to 180 mm. of water).

Punctures are to be performed at intervals varying with the individual case. Of course, the initial tap is necessary for diagnostic purpose. Taps may be repeated every 12 to 24 hours to relieve headache, marked restlessness, increasing stupor, undue rises in temperature, advancing papilledema, slow pulse, or convulsions. Rigidity of the neck, *per se*, is not an indication for lumbar puncture as it may re-

3. Strauss, I.; Globus, J. H., and Ginsburg, S. W.: Arch. Neurol. & Psychiat., 1932, 27:1080.  
4. Russel, C. K.: Canad. M. A. J., 1933, 28:133.

main for a long time after symptoms of intracranial tension have disappeared.

Spinal tap should not be done unless the above indications *exist* or if the patient is making satisfactory progress, since the withdrawal of spinal fluid is attended with some danger. There are those who hold that the underlying disease of the ruptured blood vessel in these cases is of a nature which predisposes to faulty closure of the wall, and facilitates recurrence of the bleeding. They, therefore, believe that the lowering of the intracranial pressure by repeated lumbar punctures *may* interfere with the organization of a blood clot by encouraging further leakage. However the authors of this paper have found the judicious use of lumbar tap apparently beneficial.

The question of reducing increased intracranial pressure and edema of the brain by the intravenous use of hypertonic solutions and by dehydration is still a moot point. These procedures are probably harmless even if of doubtful benefit.

A patient who has recovered from the initial effects of spontaneous subarachnoid hemorrhage and in whom the bleeding has evidently ceased, should be kept at rest in bed for three to six weeks. Straining, as on the bed-pan, must be prevented. It is supposed that at the end of three to six weeks, in these cases, firm enough organization of the clot should have taken place to allow the patient to get up. He

must be urged to avoid strenuous exertion, physical or mental, for the rest of his life.

#### SUMMARY AND CONCLUSIONS

Fifty cases of spontaneous subarachnoid hemorrhage were observed in two hospitals in a period of about three years. This should indicate the relative frequency of this disorder, and emphasize its importance as a clinical entity.

The pathology, etiology, clinical course, prognosis and treatment are discussed.

Of the 50 cases, 31 were male, 19 female. Ages varied from eight to 71 years, the majority occurring between 30 to 60. Twenty-two of the 50 cases were fatal.

The association of spontaneous subarachnoid hemorrhage with hypertension is frequent and has not hitherto been sufficiently stressed. In this series, 66 per cent of the patients had high blood pressure. Hypertension may cause the "blowout" of a congenital aneurysm by overloading the cerebral circulation; or, hypertension may lead to atherosclerotic disease of the arteries of the circle of Willis with or without aneurysmal formation and consequent rupture of the arterial wall. All discussions and treatises on the complications of hypertensive vascular disease should include mention of spontaneous subarachnoid hemorrhage.

The existence of hypertension adds to the gravity of the prognosis. This is shown by the fact 68 per cent of the fatal cases in this group were accompanied by hypertension.

#### DRAFT BOARD'S LAMENT

Ten little registrants standing in a line.  
One joined the Navy, then there were nine.  
Nine little registrants sitting on a gate,  
One broke a vertebra, then there were eight.  
Eight little registrants, talking 'bout heaven;  
One went conscientious, then there were seven.  
Seven little registrants, what a strange mix!  
One became a pilot and then there were six.  
Six little registrants very much alive.  
One went and drowned and then there were five.  
Five little registrants full of canny lore.  
One stole a pig and then there were four.  
Four little registrants, spry as they can be.

One became twenty-eight, then there were three.  
Three little registrants, all alone and blue.  
One fed his relatives, then there were two.  
Two little registrants, what can be done!  
One went to a psychiatrist, then there was one.  
One little registrant, classified 1-A.  
Physically, mentally, morally okay.  
One little registrant to tote a big gun.  
He got married and then there were NONE!

—Quoted by General Hershey in his talk before the Annual Conference of Secretaries and Editors, November 15, 1941.

## INTENSIVE ARSENOTHERAPY OF SYPHILIS IN NEW JERSEY HOSPITALS

WITH PRESENTATION OF A RECORD-FORM FOR THE ESSENTIAL DATA ON THESE CASES

MILTON I. ROEMER, M.D.\*

Recent trials of the massive-dose method of arsenotherapy of syphilis in several New Jersey institutions have indicated the advisability of some form of standardization or uniform record system for this important practice. The State Department of Health has undertaken to provide at least the latter so that an intelligent evaluation of results as carried out by scattered institutions can ultimately be made.

The introduction of the intensive arsenotherapy of syphilis in 1935<sup>1</sup> (or more accurately, the re-introduction of Ehrlich's original conception of the *therapia sterilizans magna*<sup>2</sup>) has created a weapon extremely valuable though still dangerous in the attack on early syphilis. The development of the organic arsenoxide, mapharsen, with the effectiveness of the arsphenamines at much smaller dosages has permitted the administration of greater quantities of spirocheticidal drug in shorter periods of time. The advantages of the massive-dose treatment are both clinical and epidemiological and have received increasing recognition from syphilologists and public health authorities throughout the country.

Clinically, the effectiveness of the rapid method is as good as or better than the most desirable course of continuous alternating treatment in the usual manner. But in face of the fact that the vast majority of syphilitics starting therapy throughout the country never complete the longer course of treatment, that is, receive only inadequate therapy,<sup>3</sup> the special desirability of a method insuring an adequate total dosage can be appreciated. It is almost academic to speak of cure-rates by the

Coöperative Clinical Group course of therapy when high delinquency-rates mean that only a small fraction ever actually receive this course. And when it is recognized that—from the point of view of the late pathological effects of syphilis against which all anti-luetic therapy is ultimately directed—inadequate therapy may often be worse than no therapy at all, the desirability of a method more efficient than the burdensome routine of one to two or more years of therapy is further emphasized.

*From the public health point of view, of course, the early infectious syphilitic is rendered promptly non-infectious by the massive-dose treatment and is taken out of hazardous circulation at the time of maximum communicability.* Economically, the cost of a short period of hospitalization for intensive arsenotherapy is considerably less than the cost of maintaining the average syphilitic under treatment—considering the cost of clinical and exhaustive follow-up services—for the prescribed period. In one New Jersey hospital which had been hospitalizing early, infectious syphilis until surface lesions were fully healed, the total period of hospitalization has been reduced, under the intensive therapy regime, by 75 per cent.

The entire system of intensive treatment of syphilis is, of course, still in an experimental phase and many variations on the originally devised intravenous drip have been developed—particularly various combinations of multiple injections given over a short period of time.<sup>4</sup> Despite the fact that blood arsenic levels, excretory rates, and toxic effects have been shown to be essentially the same by the multiple injection as by the continuous drip method,<sup>5</sup> the latter has proved to be the only method tried in New Jersey.

\* Bureau of Venereal Disease Control, State Department of Health.

1. L. Chargin, W. Leifer and H. T. Hyman, "Application of Intravenous Drip Method to Chemotherapy as Illustrated by Massive Doses of Arsphenamine in Treatment of Early Syphilis," *Journal of the American Medical Association*, March 16, 1935, Vol. 104, p. 878.

2. John H. Stokes, *Modern Clinical Syphilology*, Philadelphia, 1936, p. 289.

3. H. T. Hyman, "A Critical Evaluation of the Results of Routine Conservative Treatment of Syphilis," *Bulletin of the New York Academy of Medicine*, June, 1941, p. 467.

4. E. W. Thomas and G. Wexler, "Rapid Treatment of Early Syphilis with Multiple Injections of Mapharsen," *American Journal of Public Health*, June, 1941, Vol. 31, p. 545.

5. H. J. Magnuson, B. O. Raulston and A. Muff, "The Toxic Dose of Mapharsen Given in Interrupted Doses," *Venereal Disease Information*, Dec., 1941, Vol. 22, p. 431.



To date, twelve hospitals in ten municipalities throughout New Jersey are known to have begun treatment on at least one syphilitic by the intensive arsenotherapy method. There may be others that have not come to the attention of the Bureau of Venereal Disease Control of the State Department of Health. The bulk of the total number of patients treated, however, has been handled in one institution, the Essex County Isolation Hospital at Belleville—where an energetic program is carried on for the major venereal disease treatment centers in Essex County. But the new technique is spreading gradually and increasing numbers of general hospital beds are being provided for its use.

Highly variable methods of executing the method of the five-day-continuous-intravenous-drip originally devised by the Mount Sinai Hospital group in New York have been encountered. Hardly two institutions have used the identical routine and many irregular departures from the recommended procedures have been observed. The total dosages given have varied widely. The solvents for the intravenous infusion have varied. The toxic effects considered contraindications to continuance of the treatment have been different. Treatment has been stopped, for example, after a slight primary fever and not resumed—whereas it should have been resumed after the temperature subsided. The stages of the disease submitted to intensive treatment have been unusual including a late latent case in one institution and several cases of late central nervous system syphilis in the Trenton State Hospital. Trivial administrative problems—such as need for the occupied bed by another patient or the displeasure of the syphilis patient, with voluntary termination of the treatment—have interfered with the proper routine.

All of these difficulties have pointed up the need for some uniform method of administering the rapid method of arsenotherapy in New Jersey hospitals—or at least a uniform record system, so that what happens to patients handled in different ways will be ascertainable in the future. Variability in methods is not, in itself, undesirable so long as essential data for ultimate evaluation is kept. For this reason

the Bureau of Venereal Disease Control of the State Department of Health has prepared a record-form for use on all cases of syphilis treated by the massive-dose method. On this form, space is provided for recording all essential data which may be of importance in ultimate appraisal of the outcome of the particular case.

The Hospital Course Record (Figure 1) includes identification data, including past illnesses which may have a bearing on tolerance to the therapy. The diagnosis, clinical and laboratory, is indicated; the details of the therapy course including any associated medication; treatment reactions, clinical or laboratory; and any special difficulties involved in the particular case such as associated gonorrhea with sulfonamide therapy. Under treatment reactions only the significant toxic effects need be recorded; under laboratory findings all of the important examinations are provided for.

The Follow-up Record (Figure 2) indicates all the essential points to be investigated on the patient's return. Particularly important is a search for relapse muco-cutaneous lesions as well as the subsequent serologies. It has been discovered that at one clinic seeing a considerable number of intensively treated cases, no regular search for relapse lesions was made, so that an evaluation of the true outcome of these cases is difficult to arrive at. The desirable times of follow-up are indicated as being once a month for the first year, every two months for the second year, and every six months for the third to fifth years. Padgett's recent long-run studies on the outcome of early syphilis<sup>6</sup> give considerable evidence that a "five-year cure" in syphilis may be regarded as permanent.

At the Newark Health Department Venereal Disease Clinic, where the largest number of these cases have been followed in New Jersey, it has been found effective to supplement the hospital therapy with weekly injections of bismuth subsalicylate until the serology has been reversed. Dr. Exner reports that by this plan the time required for sero-reversal in the first

6. P. Padgett, "Long-term Results in the Treatment of Early Syphilis," *American Journal of Syphilis, Gonorrhea, and Venereal Diseases*, November, 1940, p. 716.

56 cases studied has been cut from the Mount Sinai average of eighteen weeks to an average of ten weeks.<sup>7</sup>

It can reasonably be anticipated that the intensive short-term arsenotherapy of early syphilis will be a commonplace form of treatment in the future. As soon as further study succeeds in detecting the mechanism of and possibly eliminating arsenical encephalitis (apparently not "hemorrhagic"), the toxic complication which has caused the only fatalities, rapid spread of the method may be expected. The current nation-wide fatality-rate of 0.30 per cent,<sup>8</sup> however, cannot be considered alarming when it is realized that a considerably higher fatality-rate occurs from syphilis itself among the vast numbers of early cases starting treatment by the routine method and not completing it.

The ultimate elimination of syphilis as a vast public health problem depends on the prompt treatment of the infectious case. If all infectious cases in America could be "chemically quarantined" by treatment at once, syphilis would be reduced to a disease of trivial proportions within a generation. Nothing has made the possibility of this accomplishment seem closer than the development of the short-term massive-dose method. It is hoped that New Jersey syphilologists will familiarize themselves and develop proficiency in the intensive method and that New Jersey hospitals will open their doors wider for the hospitalization of such cases. The record-forms presented here may be of value in collecting the essential data on these cases for their proper ultimate evaluation.

FIGURE 1

## N. J. STATE DEPARTMENT OF HEALTH

## BUREAU OF VENEREAL DISEASE CONTROL

*Intensive Arsenotherapy Cases**Hospital Course*

NAME.....	Age.....	Weight.....
Sex.....	Marital Status.....	Color.....
Address 1.....		
2.....		
Past Illnesses: Cardiac.....	Renal.....	Liver..... Allergy.....
HOSPITAL WHERE TREATED .....		
Physician-in-Charge .....		Assistants .....
DIAGNOSIS: Primary .....	Darkfield: Positive .....	
(check) Secondary .....	Negative .....	
Infectious relapse .....	Not done .....	
Other (specify) .....	Serology .....	
	(before treatment)	
THERAPY COURSE: Drug.....	Date: Begun.....	Ended.....
Schedule of Administration in Detail		
Daily dosage .....		
Solvent used .....		
Daily quantity of infusion .....		
Average daily duration of infusion.....		
Actual number of days treated.....		
Total Dosage Received.....		
Concomitant Therapy .....		

7. M. J. Exner, *Report on the Treatment of Early Syphilis by the Massive Dose Five-Day Drip Method*, Dept. of Health, Newark, N. J., 1942 (mimeographed).

8. D. C. Elliott, G. Baehr, L. W. Shaffer, G. S. Usher and S. A. Lough, "An Evaluation of the Massive Dose Therapy of Early Syphilis," *Journal of the American Medical Association*, October 4, 1941, Vol. 117, p. 1160.

Difficulties in management, associated illnesses, unusual occurrences, etc.

FOLLOW-UP RECORD

[illegible]

NOTE—Every case should be seen, if possible, every month for the first year after completion of intensive arsenotherapy, every two months for the second year, and every six months for the third, fourth and fifth years. If supplementary treatment (bismuth) is given, of course, cases may be seen weekly or as desired.



## THE MANAGEMENT OF TOXEMIAS OF PREGNANCY \*

## MATERNAL WELFARE ARTICLE NUMBER SEVENTY-THREE

CARL H. ILL, M.D., Newark, N. J.

In 1937 the American Committee on Maternal Health set up a new and very much more simple classification of the toxemias of pregnancy. This was divided into four groups: A, Diseases not peculiar to pregnancy; B, diseases dependant upon or peculiar to pregnancy; C, vomiting of pregnancy; and D, the unclassified toxemias. This paper will discuss only groups A and B.

Under Group A, diseases not peculiar to pregnancy, we have (1) hypertensive cardiovascular disease, (a) benign and (b) malignant; (2) renal disease, (a) chronic vascular nephritis or nephrosclerosis, (b) glomerulonephritis, acute and chronic, (c) nephrosis, acute and chronic, (d) other forms of severe renal disease.

1. Hypertensive Disease: Hypertensive disease is nothing more than a rise in blood pressure and occurs in one-fourth of all cases of toxemia of pregnancy and yet is not a toxemia of pregnancy. It is apparently aggravated by pregnancy and in some respects simulates pre-eclampsia as well as renal disease. There is no other pathology present. (a) In mild cases the blood pressure rises from 130-140 systolic and under 100 diastolic. There are no eye ground changes. In the more severe types of the benign cases blood pressure will go up to as high a 160 systolic and over 100 diastolic. There will be no albumin in the urine and the eye grounds will reveal alterations in the retinal vessels. Our treatment for the simple cases is (1) a sodium iron-poor diet, this particularly includes salt and bicarbonate of soda; (2) rest in bed. We admit to the hospital all cases whose blood pressures go above 150 systolic or above 100 diastolic. (b) Malignant type of hypertension. There is a great deal of controversy over whether there is truly a malignant type of hypertension. It is so exactly similar to pre-eclampsia and too difficult to distinguish from it, that, for the sake of

clearness, I have grouped it entirely under that heading. Even Kellogg<sup>1</sup> has never been able to make a definite diagnosis of this disease. Herrick and Tillman<sup>2</sup> have definitely shown, and after a long follow-up period, that these original hypertensive women all have high blood pressure when they get older and usually die from some cerebral accident if they don't die from something else first.

2. Renal Disease: Most cases of renal disease can be gotten through the history because it most always antedates pregnancy. The first disturbances are usually persistent headaches, weakness, and edema. Later symptoms and signs are visual disturbances, pale waxy skin, high blood pressure and the usual other signs of chronic renal disease. As pregnancy progresses the symptoms become gradually worse. Fortunately most women abort or have premature labors. If they don't, they might go into a true eclampsia or a uremia. Prognosis: In very mild cases if convulsions or uremia do not set in, one might bring a patient through satisfactorily. Every pregnancy, however, definitely shortens the life of a nephritic woman and she should not be allowed to have too many children. I will not go into the treatment because it is the same as the treatment for all nephritis.

At this time I would like to report a case who was sent to us on April 10, 1941, five months pregnant. Past history showed rheumatic fever at seventeen and recurrent kidney infection with no nitrogen retention. Weight was 133 pounds, blood pressure 130/70, and there was a generalized edema. Urine showed four-plus albumin, hyaline and granular casts. Her blood chemistry was normal except for a 4.3 milligram uric acid. Her plasma protein was 3.6 and a sodium chloride was 410. Hemoglobin was 63 per cent. A hysterotomy was

\* Presented before Section on Obstetrics and Gynecology, at the Annual Meeting of The Medical Society of New Jersey, April 22, 1942.

1. Kellogg, F. S.: The Classification of Hypertension and Albuminuria in Pregnancy. Proc. First Am. Cong. on Obst. & Gynec., Evanston, Am. Comm. Maternal Welfare, 1941.

2. Herrick, W. W., and Tillman, A. J. B.: Mild Toxemias of Late Pregnancy; Their Relation to Cardiovascular and Renal Disease. Am. J. Obst. & Gynec., 31:832-844, May, '36.

done from above with no severe reaction. The plasma protein on numerous tests since then has gradually come up to 5.85 and the hemoglobin to 85 per cent. Albumin still is four-plus with hyaline and granular casts. Blood chemistry is normal.

Pyelonephritis may occur in either acute or chronic form. A good many of these cases have developed or develop prior to the appearance of the pyelitis, an infection of the true kidney parenchyma which results in permanent renal damage. All these cases should be rigorously treated and carefully followed. Very often it is difficult to make a diagnosis of renal disease during pregnancy and it only can be made definitely some months post-partum.

Group B, Toxemias: The best definition of toxemia of pregnancy that I have been able to find was by Dexter and Weiss.<sup>3</sup> It may be defined as the appearance in the latter half of pregnancy of (1) an abnormal elevation of the blood pressure above the pre-pregnant level (regardless of the presence or absence of hypertensive disease before the onset of pregnancy); (2) an increase above the pre-pregnant level of albumin in the urine in the absence of pyuria and hematuria; or (3) a diminution of these abnormalities before or some time after delivery. This group is composed of the true toxemias of pregnancy which are now divided into grade one, mild pre-eclampsia; grade two, severe pre-eclampsia; and eclampsia.

Grade One, mild pre-eclampsia: Patients with the old recurrent toxemia of Kellogg; low reserve kidney, Stander; mild pre-eclampsia, Herrick, are those individuals who developed for the first time in the last trimester of pregnancy a systolic blood pressure of 140-160 and a diastolic of 90-100 millimeters of mercury. The urine usually contains less than .6 gram of albumin per liter, and edema is usually slight or absent. Eye ground symptoms associated with the pre-convulsive state are not present. These cases with even very little treatment go on to term and deliver without any further trouble. The treatment, of course,

is rest and a salt-free diet. It must be definitely remembered that it is entirely possible and very often happens that you get a real pre-eclampsia superimposed upon a pre-existing hypertension or even superimposed upon any type of kidney disease.

Grade Two, severe pre-eclampsia: This group is made up of patients who develop a systolic blood pressure of over 160, a diastolic pressure of over 110. All of them excrete more than .6 gram of albumin per liter. The amount of edema is variable but is marked in most cases. Many of these patients have one or more of these premonitory symptoms of impending eclampsia such as severe frontal headache, blurred vision, epigastric pain, vomiting, torpor or irritability. The eye grounds of these patients are essentially normal and this is the main differentiation between hypertension and the pre-eclampsias.

Grade Three, eclampsia: Eclampsia is pre-eclampsia with convulsions. Almost always there are prodromal symptoms but occasionally there is a fulminating type which seems to come out of a clear sky. The treatment of eclampsia is now almost universally conservative. It is, of course, unnecessary to state that far and away the best treatment is prevention. In every large clinic these cases have adequate prenatal care and rarely come to an eclampsia. A patient should immediately be placed in a quiet darkened room and given some form of sedation, either morphine or sodium luminal and large doses of magnesium sulphate. This is usually given in a 50 per cent solution intramuscularly, initial dose 6 cubic centimeters and 2 cc. after every convulsion. Maximum amount 20 cc. in 24 hours. Chloral hydrate, 30 grains in 100 cc. of starch water, is given by rectum every six to twelve hours. The intravenous injection of from 500 to 1,000 cc. of 20 per cent glucose is given two or three times daily and should take one hour to give. If diuresis is not started this way 200 to 400 cc. of 50 per cent solution should be given. After the convulsions are controlled you have to decide upon how to deliver this woman. If the cervix is ready, that is, partially dilated and flat, simple rupture of the membranes will almost always

3. Dexter, L., and Weiss, S.: *Pre-eclamptic and Eclamptic Toxemia of Pregnancy*. Boston, Little Brown & Co., 1941.

start labor. Some authors recommend small doses of pitocin and some are still very much afraid to use this on account of its antidiuretic action. Caesarian section should only be done after the fits are definitely controlled and only if the cervix is not right and the head high, or if you expect a long and difficult labor for any reason. I believe it is very essential to deliver a woman as soon as her convulsions are controlled and you have her over the period of likelihood of shock. This usually means when diuresis is well established. In Dexter and Weiss' new monograph<sup>3</sup> there are two sentences following one another talking about the prognosis of eclampsia. (1) The earliest sign of impending disaster has usually been an insidious, unexplained, and progressive fall in arterial pressure. (2) The most reliable sign of improvement has been diuresis, and until

diuresis occurs improvement has rarely taken place.

The case of nephritic toxemia which I quoted before led us to do considerable plasma proteins in normal cases to see if we could find any relationship between the toxemia and the hypoproteinemia. We studied twenty normal cases and found that the plasma protein gradually went down from the normal, at five months, to an average of 6.34 at delivery, and very soon thereafter went back to normal. In the abnormal cases that we had the plasma protein was definitely related to the amount of edema of the patients. We had one case of eclampsia who died and the plasma protein was 6.73. This work, of course, has been done before, especially by Dexter and Weiss,<sup>3</sup> and also by other workers but very little of it has come into obstetrical literature.

188 Clinton Avenue

## A LESSON FROM A DEATH CERTIFICATE

### NUMBER FORTY-FOUR

History of three difficult labors, two of which resulted in stillborn babies. After six hours in labor a section was done. Membranes were intact.

On the eighth day, a few hours after sutures had been removed, the whole abdominal inci-

sion opened. No pus in abdomen. Infection continued and patient died.

How did the abdominal wound become infected?

A. W. BINGHAM, M.D.

## DIGITALIS

The attention of physicians is called to the fact that the new U. S. P. XII "Powdered Digitalis" and the new U. S. P. "Tincture of Digitalis" are materially reduced in potency when compared with the U. S. P. XI "Powder" and "Tincture". All other digitalis preparations, tablets, capsules, injections, etc., which have been heretofore standardized in

terms of the U. S. P. Digitalis Reference Powder which has been issued during recent years by the U. S. P. Board of Trustees and which have been assayed by the U. S. P. XI, one-hour frog method, will also be materially reduced in potency when assayed by the new U. S. P. XII cat method, using the new U. S. P. Digitalis Reference Standard (1942).

## A BOOSTER

The Bell Telephone Company in a recent leaflet calls attention among other things to New Jersey's important rôle in the medical world and points out the fact that our Society

is the oldest in this country. The leaflet emphasizes the high purpose for which the Society was founded in 1766.



## EXECUTIVE OFFICER'S PAGE

The members of The Medical Society of New Jersey are going into service at an increasing speed. Our plans and committee memberships will need to be frequently and materially revised. The dues paid by the members form the major portion of our income. To avoid increasing the assessment on the reduced number of members remaining at home, we must watch our expenditures. We are already committed to no inconsiderable expenditures for our approved activities for this fiscal year. The Government will probably increasingly assume still more of the cost of our war integration efforts. All activities must be periodically studied as to possible economy, but in all cases we must be sure that any curtailment is a true economy with regard to the future of medical practice after the peace has been restored. While it is impossible to definitely forecast the future needs, and the ways and means best suited to meet these needs, we must continually think about this problem and have ready some tentative plans to which we will subscribe and demonstrate our support in time of peace.

Our President, Dr. Marsh, has emphasized the preservation of our professional standards and integrity. This aim is important and those who go in service will participate in the greatest and most practical professional post-graduate training program ever made available to the medical profession. Our members will also take an active part in an effective and widespread organized plan for distribution of medical care to both the armed forces and the civilian population on a scale never before envisioned. There will be little time available for protracted discussion before decisions are reached. A beginning procedure must be promptly decided upon and immediately put to work. The criterion which will decide whether to continue a program or revise it and try again, will be the *results obtained*. Theory will be constantly faced with the facts, and will stand or fall by the comparison. The individual with unselfish devotion and patriotism in wartime must become a teamworker. Every man must respond to calls for help from his professional colleagues and from the public if our profession is to live up to the high ideals and example set by our worthy predecessors. Each member should keep the Society's Executive Office informed of his mail address and where he wishes us to send his *Journal*.

The gas and tires handicap will limit our Society activities and curtail visits made to

County Society meetings. This crisis should, however, tighten our bonds of fellowship and association. It will cause us to think straight and to decide quickly upon our course of action when faced with concrete problems, and to decide the specific questions of policy and procedure as they arise.

Your Executive and Editorial Staffs are well trained and competent to keep the machinery moving and in good shape to carry on the Society's approved program and projects in which our members engage.

### THE NEW PROBLEM OF GROUP SERVICE

In the past a patient has, on his own initiative, sought medical service from his own physician, and the payment for such service has been arranged by mutual agreement on the basis of the specific needs of the patient at that time. This agreement (or contract) has been verbally made or implied. We must, however, not overlook the fact that very frequently it is a "third party" who brings together the patient and the doctor. This third party may be a friend who has met, or at least heard of the doctor in question, and then suggests his name to the prospective patient. Another patient may be the third party. Frequently the "third party" is a nurse or a layman. The same idea is carried out now in connection with the newer development of service to groups. Such services are usually prepaid by a monthly premium as insurance, and are accepted for specified services given, when as and if needed, by any of the participating physicians to any of the members of such groups. The third party in these plans is usually an organization which, in a business-like way, arranges the financial and nonprofessional service details according to accepted and approved programs and plans endorsed by the participating physicians and accepted voluntarily by those who wish to join such service groups. This business-like arrangement, devised and operated by those especially trained in the field of insurance payment plans, to distribute cost, in no way interferes with the physician or his freedom of professional procedure. He meets the needs of each patient as in his judgment they are best served on each occasion when he attends them. Surely there can be desirable types of "third persons" as well as undesirable types. When we arbitrarily rule out all third parties, are we not working against the best interest of our patients and our members?

## STATE ACTIVITIES

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### LIST OF CURRENT OFFICERS AND COMMITTEE MEMBERS

A list of the elected officers and committee members and those appointed by the President is published in this Journal. The compilation of these committee lists this year has been a difficult task due to the rapidity with which our members have already entered the armed forces and are still continuing to enlist. It is likely that

such frequent changes will continue through the year and make it inadvisable to attempt to carry a complete list of committee members in The Journal as usual. A list will always be available in the Executive Offices and any information regarding committee members can be obtained by contacting the Office.

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### MEETING PLACE OF THE 1943 ANNUAL MEETING

The Haddon Hall Hotel in Atlantic City has been taken over "for the duration" by the government for the use of aviation cadets. It will therefore be impossible for The Medical Society of New Jersey to hold the annual meeting there in 1943 as we planned. It is

likely that the meeting will be materially curtailed in both content and time since economy in time as well as money will be essential for the duration. The Annual Meeting Committee and the Trustees will decide this important matter and you will be promptly advised as to their final decision.

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### INDUSTRIAL MEDICINE

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By LEVERETT D. BRISTOL, M.D., Dr. P.H., New York

Educational needs in the field of industrial health may be considered from three standpoints: (1) The education of the worker himself with reference to his health; (2) the education of management and labor as to the needs and values of health and medical work in industry; and (3) the education of those who render professional services to industry, particularly the medical practitioner or specialist. In this presentation, I shall refer only to the latter, with emphasis on post-graduate education.

The Council on Industrial Health of the American Medical Association has expressed its willingness to assist in the development of intensive training in industrial health for full-time and part-time industrial physicians, through its organization of committees on industrial health in State Medical Societies. The Council already has acquired information on all major medical agencies interested in employee health; the available facilities for under-graduate and post-graduate industrial medical training in the United States; as well as other data of potential value in an industrial health program as a part of our war-time ef-

forts. Speaking as a member of the Council, which is a standing committee of the Board of Trustees of the American Medical Association, we welcome the coöperation of the Associated State Post-graduate Committees of the State Medical Societies in all matters pertaining to the advance of post-graduate industrial medical education in the United States. We particularly would emphasize the value of coöperative relationships of committees (a) on industrial health and (b) on post-graduate medical education in the State Medical Societies.

#### WAR-TIME NEEDS

There are approximately fifty million wage-earners in the United States. Among these workers, it has been found that over four hundred million days are lost per year on account of absenteeism due to sickness, with a resulting yearly cost of over three billion dollars. We must do everything possible to save this time lost from sickness, as a part of our contribution to winning the war. Neither metal nor rubber, money nor man-power—but time shows the greatest shortage! Our present needs require a strengthening and broadening

of the entire industrial health program all along the line from private industry to local, state and federal jurisdictions. As emphasized by Surgeon General Parran of the United States Public Health Service, "Industrial hygiene must keep pace with the needs arising from high-speed assembly lines, which will employ some fifteen million men and women within the year. Great Britain learned that it is urgently necessary to have the full-time services of a trained industrial physician in every large plant. Less than one-seventh of our workers have that service now."

As a further indication of the need for promoting more adequate health services for war-time workers, is the fact that in 1941 there was a 12 per cent increase in disabling cases of sickness and non-industrial injuries among male employees of various industries as compared with the mean for the last ten years. Lost time from work on account of sickness, under present conditions, is a potential form of unintentional sabotage. This hidden waste must be brought under better control as a part of our war efforts. As recently stated by Mr. Paul V. McNutt, "Although modern warfare depends on industry just as much as on armed forces, measures to maintain the health and morale of defense workers are far inferior." Moreover, it has been said that, "in time of peace, industrial hygiene is a tool; in time of war, we must make it a weapon!"

One of the chief and immediate needs in connection with the national emergency calls not only for more and better undergraduate instruction in industrial health in our medical schools, but also for the organization of short post-graduate courses or institutes in strategic centers throughout the United States. One re-

sult of the marked advance in the development of Bureaus of Industrial Hygiene in state and local governments has been an increased demand for trained personnel which it has been difficult to meet. Many war-production industries also are finding it difficult to obtain the services of properly qualified medical personnel. With the practical exhaustion of the supply of competent industrial physicians, we must depend largely on physicians active in community practice.

Depending somewhat on the length of time available and on local conditions and facilities, the content of a post-graduate course, continuation study, or institute in industrial health should cover: (1) Employee Relations; (2) Management Relations; (3) Medical Relations, and (4) Public Health Relations. The first two involve the demand or need for industrial health services, the last two—the supply of such services. Among the specific subjects which should be included are: (a) Common industrial health problems, including dust hazards, industrial dermatitis, and other industrial diseases of local bearing or interest; (b) control of tuberculosis, syphilis and other non-occupational diseases among industrial workers; (c) emergency care of major and minor industrial injuries; (d) the industrial hygiene survey, with demonstrations of methods and apparatus; (e) medico-legal aspects of industrial health; and (f) industrial health and the general practitioner, including methods and procedures regarding administration and physical examinations.—Extracts from an address presented before the Annual Meeting, Associated State Post-graduate Committees of the State Medical Societies, Atlantic City, June 10, 1942.

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## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

The following list covers June and July, 1942:

BRAKELEY, ELIZABETH (Montclair), and SHAUL, JOHN F. (Bloomfield)

Pediatric aspects of the tonsil and adenoid problem. *Arch. Pediat.*, 49:347-355, June 1942.

BUNNEY, WILLIAM EDWARD (New Brunswick)—See Holm, August

CARDWELL, EDGAR P. (Newark)

Surgical management of diseases of the temporal bone. *Dis. Eye, Ear, Nose and Throat*, 2:182-186, June 1942.

CARPENTER, CEDRIC C. (Summit)

Minimum requirements for venereal disease clinics. *Urol. and Cutaneous Rev.*, XLVI, No. 7, 1942.

D'ALESSANDRO, ARTHUR J. (Newark)

Vitamin K and its rôle in blood coagulation. *Am. J. Surg.*, 57:104-111, July 1942.

FINKLER, RITA S. (Newark)—See Friedman, Milton

FRIEDMAN, MILTON, and FINKLER, RITA S. (Newark)

Treatment of sterility with "small dose" x-ray therapy. *Amer. J. Obst. & Gyn.*, 43:852, May 1942.

FRYCZYNSKI, MARYA (Jersey City)—See Gerber, Isadore E.

GERBER, ISADORE E., and FRYCZYNSKI, MARYA (Jersey City)



Use of heparinized blood in studies with congo red and bromsulphalein. *Am. J. Clin. Path.*, 12: 312-315, June 1942.

GNASSI, ANGELO M. (Jersey City) See Rundlett, Emilie

HOLM, AUGUST, and BUNNEY, WILLIAM EDWARD (Squibb Institute, New Brunswick)

Potency-determination of antipertussis serum by the mouse-protective test. *J. Immunol.*, 43:33-39, May 1942.

JAFFIN, ABRAHAM E. (Jersey City)—See Kruger, Alfred L.

KRUGER, ALFRED L.; POTTER, BENJAMIN P., and JAFFIN, ABRAHAM E. (Jersey City)

Management of the minimal tuberculous lesion. *Am. Rev. Tuberc.*, 46:50-58, July 1942.

NICHOLS, STANLEY (Asbury Park)—See Raffetto, Joseph

NICOLA, TOUFICK (Montclair)

1. Anterior dislocation of the shoulder. *J. Bone & Joint Surg.*, 24:614-616, July 1942.

2. Use of curved spirit levels in orthopedics. *Am. J. Surg.*, 57:191-192, July 1942.

POTTER, BENJAMIN P. (Jersey City)

1. Study concerning clinical and anatomical fea-

tures of reexpanded lungs which had been collapsed by pneumothorax for variable periods of time. *J. Thoracic Surg.*, 11:554-564, June 1942.

2. See Kruger, Alfred L.

PRICE, PRESTON (Jersey City)—See Rundlett, Emilie

RAFFETTO, JOSEPH, and NICHOLS, STANLEY (Asbury Park)

Nearly fatal reaction to sulfadiazine in a ten-year old girl, involving skin, eyes and oropharynx. *J. Pediat.*, 20:753-755, June 1942.

RUNDLETT, EMILIE; GNASSI, ANGELO M., and PRICE, PRESTON (Jersey City)

Meningococcic meningitis: Prognostic significance of the spinal fluid sugar. *J. A. M. A.*, 119: 695-696, June 27, 1942.

SACHS, WILBERT (Jersey City), with DEOREO, GERARD (Cleveland)

Lichen planopilaris; lichen planus et acuminatus atrophicus (Feldman) and lichen spinulosus and folliculitis de calvans (Little). *Arch. Dermat. & Syph.*, 45:1081-1093, June 1942.

SHAUL, JOHN F. (Bloomfield)—See Brakeley, Elizabeth.

## SUPPLEMENTARY LIST OF MEMBERS NO. 5

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### ACTIVE MEMBERS

Atkinson, John M., 93 Greenwood av., Madison (14)  
Benjamin, Jos. F., 203 Godwin av., Ridgewood (16)  
Connelly, John H., 45 Marion av., Newark (7)  
Darby, C. Eugene, 620 Atlantic av., Ocean City (5)  
DeFelice, Mario T., 28 Mt. Airy rd., Bern'dsville (14)  
Gencher, Benjamin, 24 Ravine av., Caldwell (7)  
Hofer, William, 1176 Kaighn av., Camden (4)  
Kyle, Ernest I., 1185 Park av., Plainfield (20)

Manser, Ernest E., 324 Haddon av., Collingswood (4)  
Meisel, David B., 818 S. 12th st., Newark (7)  
Papera, John J., 12 Sutton pl., Verona (7)  
Rizzoli, Luigi, 15 Peck av., Newark (7)  
Rothgesser, Jerome C., Brookley Fd., Mobile, Ala. (7)  
Snake, William J., 24 First av., Runnemede (4)  
Wambsganss, M., 44 Devine st., Newark (7)  
Young, John H., 37 N. Fullerton av., Montclair (7)

## MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES SUPPLEMENTARY LIST NO. FOUR

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Adelman, Nathan, Newark (7)  
Albert, Perry, Trenton (11)  
Altschul, Frank J., Long Branch (13)  
Arbeit, Sidney R., Jersey City (9)  
Atkinson, John M., Madison (14)  
Barr, Joseph, Paterson (16)  
Barrett, Joseph F., Maplewood (7)  
Becker, Martin, East Orange (7)  
Belafsky, Henry A., Woodbridge (12)  
Belfer, Jacob J., Trenton (11)

Bendix, Gerhard M., Somerville (18)  
Benjamin, Joseph F., Ridgewood (16)  
Bennett, Robert E., Trenton (11)  
Bertha, Nicholas A., Wharton (14)  
Betts, R. Winfield, Medford (3)  
Blum, Milton, Jersey City (9)  
Bonanno, Peter J., North Bergen (9)  
Bonnet, W. Laurence, Mercerville (11)  
Bornstein, Paul K., Belmar (13)  
Bradasch, George A., Union City (9)

- Bresev, Morris, Jersey City (9)  
 Burrus, Thomas P., Newark (7)  
 Byck, Louis, Newark (7)  
 Byer, M. Yale, Trenton (11)  
 Clark, John C., Asbury Park (13)  
 Close, Byron H., Bloomington (16)  
 Cohen, Samuel, Jersey City (9)  
 Cohen, Samuel A., Jersey City (9)  
 Colby, Maxwell, Long Branch (13)  
 Cornish, Charles H., Maplewood (7)  
 Costa, Philip L., Red Bank (13)  
 DeFelice, Mario T., Bernardsville (14)  
 Deutel, Oscar R., Bloomfield (7)  
 Dow, Robert F., Paterson (16)  
 Edelson, Samuel, Neptune (13)  
 Elliott, Frazier J., Hammonont (1)  
 Failmeizer, Theodore R., Madison (14)  
 Faux, Frederick J., Woodbury (8)  
 Feller, William, Jersey City (9)  
 Fenton, Tennant E., Spring Lake (13)  
 Frank, Nathan, Jersey City (9)  
 Freedman, Harold H., Freehold (13)  
 Freyberger, George, Weehawken (9)  
 Garber, Robert S., Trenton (11)  
 Gilbert, Philip D., Camden (4)  
 Gilmour, John R., East Orange (7)  
 Gleason, Thomas P., Bayonne (9)  
 Goff, Frank J., Red Bank (13)  
 Goldman, Jerome, Maplewood (7)  
 Grieco, Emil H., Bayonne (9)  
 Gurshman, Sol, Metuchen (12)  
 Haley, Paul W., Newark (7)  
 Hancock, Michael Q., Belmar (13)  
 Handler, Harry, Jersey City (9)  
 Hardy, John W., Farmingdale (13)  
 Harvey, Robert K., Arlington (7)  
 Hatcher, George A., Cedar Grove (7)  
 Hebble, Howard M., Moorestown (3)  
 Heyman, Arthur, Newark (7)  
 Hughes, Samuel B., Wildwood (5)  
 Hull, Donald B., Ridgewood (2)  
 Imhoff, Robert E., Moorestown (3)  
 Infield, Gerald L., Northfield (1)  
 Jennings, Robert E., East Orange (7)  
 Jordan, Joseph C., Manasquan (13)  
 Landis, Harry P., Palmyra (3)  
 Landshof, Charles, Jersey City (9)  
 Lang, Richard E., Passaic (16)  
 Lawless, Edward T., East Orange (7)  
 Leach, John E., Paterson (16)  
 Levinson, Reuben, Perth Amboy (12)  
 Lintz, Sidney Z., Swedesboro (8)  
 Long, John F., Harrison (7)  
 Lynn, Irving I., Jersey City (9)  
 Macchia, Benjamin J., Jersey City (9)  
 Mackin, John J., Jersey City (9)  
 Marcus, Donald, Irvington (7)  
 Matthews, Clifford, Newark (7)  
 McBride, Andrew F., Jr., Paterson (16)  
 Metzger, Freeman W., Riverside (3)  
 Miller, Reginald C., Trenton (11)  
 Monfort, Robert N., Jersey City (9)  
 Muldoon, Edward J., Florence (3)  
 Mustermann, Otto H., Union City (9)  
 Newmeyer, Joseph, Delanco (3)  
 Palazzo, William L., Boonton (14)  
 Payne, Guy, Jr., Verona (7)  
 Piltz, George F., Guttenberg (9)  
 Podell, A. Alfred, Red Bank (13)  
 Potter, Benjamin P., Jersey City (9)  
 Quirk, Martin A., Red Bank (13)  
 Raffetto, Joseph, Asbury Park (13)  
 RePass, Paul E., East Orange (7)  
 Reynolds, Donald G., Freehold (13)  
 Rinzier, Elliot, Newark (7)  
 Rothgasser, Jerome C., Newark (7)  
 Rothhouse, Burnet, Newark (7)  
 Saltus, Lloyd, Morristown (14)  
 Schwartz, Mortimer L., Newark (7)  
 Shanik, William, Asbury Park (13)  
 Shapiro, Saul J., Union City (9)  
 Siegel, Lester, Jersey City (9)  
 Snegireff, Leonid S., Trenton (11)  
 Sparks, Paul R., Burlington (3)  
 Stage, Earl DeW., Morristown (14)  
 Stokes, James S., Paterson (16)  
 Talmage, William G., Succasunna (14)  
 Temes, J. Howard, Jersey City (9)  
 Vana, Felix H., Englewood (2)  
 Van Sickle, Albert W., Chester (14)  
 Voss, J. Landon, Bernardsville (14)  
 Wainright, Melvin A. R., Red Bank (13)  
 Wallack, Eli A., Jersey City (9)  
 Watov, Samuel E., Trenton (11)  
 Westerhoff, Peter D., Midland Park (16)  
 Wilkins, Stanley O., Red Bank (13)  
 Woronoff, Murray, Keyport (13)  
 Wright, Herman W., Pitman (8)  
 Wright, Robert E., East Orange (7)  
 Yaguda, Asher, Newark (7)  
 Ziccardi, Anthony V., Maple Shade (3)

## STATE BOARD OF MEDICAL EXAMINERS

E. S. HALLINGER, M.D., F.A.C.S., Secretary

Following is a report of the activities of the Board in enforcing the Medical Practice Act since our last report:

January 29th, 1942. Judge Glavin of the First District Court of Jersey City found Joseph M. Voza, an unlicensed chiropractor of Jersey City, guilty of practicing medicine without a license. He was fined and paid the penalty. This was a second offense.

March 17th, 1942, Bruce O. Tegge, a registered pharmacist of Audubon, was tried before

Judge Sheehan of the First District Court of Camden and found guilty of practicing medicine without a license. He was fined and paid the penalty.

March 18th, 1942, the Board revoked the license to practice medicine and surgery of George Lemke of Flint, Michigan.

March 25th, 1942, Hester Armstrong, a colored woman of Cranford, who massaged, gave herb baths and medicines, was tried before Judge Sauer of the Elizabeth District Court

and found guilty of practicing medicine without a license. She was committed to jail for ninety days. This was a third offense.

March 30th, George Poe of Califon, an unlicensed chiropractor, pleaded guilty to a charge of practicing medicine without a license before Judge Prall of the Hunterdon County Court of Common Pleas. He was fined and paid the penalty.

April 8th, Lorenzo Ciciriello of Franklin Township was found guilty of practicing medicine without a license by the Judge of the Somerville District Court and sentenced to ten days in jail. Ciciriello diagnosed and treated people with medicines which he prepared from weeds he gathered.

April 15th, 1942, the Board revoked the license to practice midwifery of Lena Russo of Hoboken.

May 12th, 1942, James Visconti, M.D., who was found guilty of practicing medicine without a license on April 26th, 1940, abandoned his appeal and was fined and paid the penalty.

May 12th, 1942, the following persons were fined and paid penalties for practicing medicine without a license:

Herman Ades, proprietor of a drug store in Newark. He is not a pharmacist.

Maria Sensi of Trenton, a licensed midwife who exceeded her license.

Emanuel Mandell, an unlicensed chiropractor of Linden.

Henry Quitmeyer, an unlicensed chiropractor of Cranford.

Philip Manna, an unlicensed chiropractor of New Brunswick.

Herman H. Farber, an unlicensed chiropractor of Union City.

May 20th, 1942, the Board restored the li-

cense to practice medicine and surgery of Aaron L. Simon of Passaic.

June 10th, 1942, Michael Nogradi of New Brunswick, an unlicensed chiropractor, paid a penalty for practicing medicine without a license.

July 3rd, 1942, the case against George C. Weiershausen, a licensed chiropractor of Jersey City, was dismissed by Judge Glavin of the First District Court of Jersey City, before whom he was tried January 14th, 1941. Weiershausen gave electric treatments and on one occasion gave tablets to take in his office. He contended that the various electrical appliances were used solely for diagnostic purposes.

July 8th, 1942, Philip Immediate of Jersey City, a registered pharmacist, was found guilty of practicing medicine without a license by Judge Glavin of the First District Court of Jersey City, before whom he was tried May 7th, 1942. He was fined and paid the penalty.

July 9th, Edward A. Korn of East Orange, an unlicensed chiropractor, was fined and paid the penalty for practicing medicine without a license.

July 15th, 1942, the Board revoked the license to practice medicine and surgery of Samuel Roth of New York. On the same day, the Board suspended for one year the license to practice midwifery of Anna E. Opacity of Newark.

July 21st, 1942, Mendel Mendelsohn and Alexander Bell of Newark and East Orange respectively, registered pharmacists, pleaded guilty to charges of practicing medicine without a license. They were fined and paid the penalty.

August 7th, Harry B. Ulanet of Bloomfield was fined and paid the penalty for continuing to practice chiropody after having failed to obtain an annual certificate of registration.

## OBITUARY

### DR. WARREN HASTINGS SMITH

Dr. Warren Hastings Smith died in Rochester, New York, on August 11. Dr. Smith had been ill for more than a year and had only gone to Rochester several weeks ago.

He was born in Atlantic City on June 1, 1874, was a graduate of the Hahnemann Medical College of Philadelphia and served his internship in the New York City Hospital on what is now known as Welfare Island. Dr. Smith practiced in Philadelphia before coming to Newton, New Jersey. He had been licensed to practice medicine in this state since 1899, although he came to Newton in 1902 and

actively engaged in practice there until his recent illness.

He was a member of the Sussex County Medical Society, The Medical Society of New Jersey, was a Past President of the American Society of Homeopathic Physicians and the first president of the Medical Staff of the Newton Memorial Hospital. He had served as a member and President of the Newton Board of Education and Board of Health for 18 years. Dr. Smith was active in the fraternal, civic and religious life of Sussex and during World War I was one of the examining physicians of draftees.

The interment was held in Rochester, New York.



## ● THE BULLETIN BOARD ●

### **SURGEONS' CONGRESS SCHEDULED FOR CLEVELAND, NOVEMBER 17 TO 20**

*The 1942 Clinical Congress of the American College of Surgeons*, originally scheduled for October at the Stevens Hotel, Chicago, which was taken over August 1 by the United States Army Air Corps, *will be held in Cleveland, with headquarters at the Cleveland Public Auditorium, from November 17 to 20*, according to an announcement from the College headquarters in Chicago. *The twenty-fifth annual Hospital Standardization Conference sponsored by the College will be held simultaneously.*

The program of panel discussions, clinical conferences, scientific sessions, hospital meetings, and medical motion picture exhibitions at headquarters, and operative clinics and demonstrations in the local hospitals and Western Reserve University School of Medicine, has been centered around the many medical and surgical problems arising out of the prosecution of an all-out effort to win the war, emphasizing the needs of the rapidly expanding medical services of the Army and the Navy, and consideration of special problems related to the increasing activities for civilian defense.

The program of both meetings will begin with a Joint General Assembly on Tuesday morning, November 17, with addresses by Surgeon General James C. Magee of the Medical Corps, United States Army; Surgeon General Ross T. McIntire of the Medical Corps, United States Navy; Surgeon General Thomas Parran of the United States Public Health Service; Lieutenant Colonel George Baehr, Chief Medical Officer of the United States Office of Civilian Defense; Dr. Frank H. Lahey, Chairman, Directing Board, Procurement and Assignment Service; Dr. Irvin Abell, Chairman of the Board of Regents of the College and Chairman of the Health and Medical Committee of the Federal Security Agency; and Dr. W. Edward Gallie of Toronto, President of the College. The Surgeons General and Colonel Baehr will also speak at the Presidential Meeting and Convocation the same evening.

The Forum on Fundamental Surgical Problems inaugurated at the 1941 Clinical Congress will be repeated to give the younger men, representing various university departments of surgery, an opportunity to present the important results of their clinical and experimental

research work before a large surgical meeting. Heretofore these younger men have seldom been able to present their original work and ideas, since many of them have not yet qualified for membership in the principal surgical societies. The forum will be held on three successive mornings.

The officers-elect of the College who will be inaugurated at the Presidential Meeting and Convocation on November 17 are Dr. Irvin Abell of Louisville, President; Dr. Leland S. McKittrick of Boston, First Vice-President, and Dr. F. Phinzy Calhoun of Atlanta, Second Vice-President.

A large technical exhibition in which leading manufacturers of surgical instruments and supplies, sutures, dressings, pharmaceuticals, operating room equipment, x-ray apparatus and hospital equipment of all kinds, as well as publishers of medical books, will participate, will be a feature of the Clinical Congress as usual. It will be housed in the exhibit hall of the Cleveland Public Auditorium.

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### **AMERICAN COLLEGE OF CHEST PHYSICIANS**

Dr. Marcus W. Newcomb was reelected as a Governor of the College of Chest Physicians at the annual meeting held at Atlantic City, June 6-8, 1942.

The following officers were elected at a meeting of the New Jersey Chapter of the College on May 22, 1942:

Dr. Joseph R. Morrow, President, Ridgewood, N. J.

Dr. Clyde M. Fish, Vice-President, Pleasantville, N. J.

Dr. Irving Willner, Secretary-Treasurer, Newark, N. J.

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### **ROUND TABLE DISCUSSION ON ALLERGY**

At the 11th Annual Meeting of the American Academy of Pediatrics in Boston October 9-11, 1941, there was held a number of round tables on various clinical subjects. In the American Academy of Pediatrics Journal of July, 1942, pages 113-141, is found a report on the contribution of participants and discussors in this round table conference. To our members who are interested in the subject of *allergy* a review of this informative discussion would prove not only interesting but extremely practical and helpful and for this reason it is called to the attention of our membership.

**ATTENTION—COUNTY MEDICAL SOCIETY  
SECRETARIES!**

The secretary of each County Medical Society has been requested to furnish the Journal Office in Trenton, *at least two months in advance of each meeting*, a statement of the meeting place, date, hour, the name of the speaker and the title of his address. This information will be of great help to the Journal editor in his effort to insert in the Bulletin Board page, advance notice of meetings in the component societies.

Many of the larger county societies prepare early in September their scientific programs for the whole year and send an advance copy of these programs to the editor.

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**ANNOUNCEMENT OF FELLOWSHIPS IN  
MEDICINE AND PUBLIC HEALTH**

OFFERED BY THE COMMONWEALTH FUND OF  
NEW YORK THROUGH THE PAN AMERICAN  
SANITARY BUREAU

The Commonwealth Fund of New York, a philanthropic foundation established in 1918 by the late Mrs. Stephen V. Harkness, announces that it is offering through the Pan American Sanitary Bureau fifteen fellowships for one year's study of public health subjects or post-graduate medical courses to properly qualified persons who are citizens of the other American republics. Fellowships in public health will be open to physicians, sanitary officers, technicians, public health nurses, etc. These fellows will be selected through a system of cooperation with medical and health authorities of the different countries concerned, and whenever deemed advisable they will be interviewed by traveling representatives of the Pan American Sanitary Bureau. Each fellowship will provide living allowances while the holder is in the United States, travel costs, and tuition. Knowledge of the English language will be among the requirements, and also the possession of certain specific qualifications.

The Pan American Sanitary Bureau, the international health agency of the American republics, has been for some time the recognized clearing house for medical and public health fellowships in the United States, nearly 100 Latin Americans now being in the United States under its auspices.

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**THE KENNY METHOD**

Free copies of *The Kenny Method of Treatment for Infantile Paralysis* will be sent to the medical profession on request to The National

Foundation for Infantile Paralysis, Inc., 120 Broadway, New York.

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**VACANCY IN V. D. BUREAU**

There is a vacancy in the position of Medical Assistant to the Bureau of Venereal Disease Control. The salary is \$3,000 a year plus traveling expenses and requires the full-time services of the incumbent. Application should be made to the Chief of the Venereal Disease Bureau, Dr. Glen S. Usher, 1 West State Street, Trenton, N. J.

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**THE A. M. A. CASE**

Upholding the conviction for conspiracy under the Sherman Antitrust Act of the American Medical Association and the District of Columbia Medical Society, the U. S. Court of Appeals for the District of Columbia declared in a unanimous opinion June 15 that the conduct of the two medical societies went beyond "a reasonable regulation of the practice of medicine" by professional bodies. The A. M. A. has applied for a review of the conviction by the Supreme Court.

"Professions exist," says the decision, "because the people believe they will be better served by licensing especially prepared experts to minister to their needs. The licensed monopolies which professions enjoy constitute, in themselves, severe restraints upon competition. But they are restraints which depend upon capacity and training, not on special privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. There is sufficient historical evidence of professional inadequacy to justify occasional popular protests. The better educated laity of today questions the adequacy of present-day medicine. Their challenge finds support, as indicated in the margin, from substantial portions of the medical profession itself. The people give the privilege of professional monopoly and the people may take it away." (U. S. Court of Appeals, D. C., No. 7929, June 15, 1942, pp. 14-15.)

Our members are advised to read the entire article in *Medical Care*, Vol. 2, No. 3, July, 1942, pp. 274-276.

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**FILM AVAILABLE**

Dr. DeLee's film entitled "Post-Partum Hemorrhage" has recently been made available to the profession by the Petrogalar Labs., 8134 McCormick Blvd., Chicago, Ill., and may be obtained for exhibition upon application by County Medical Societies at the above address, attention of Mr. A. C. Denny, Vice-President.

## BOOKS RECEIVED FOR REVIEW

**DEMONSTRATIONS OF PHYSICAL SIGNS IN CLINICAL SURGERY.** By Hamilton Bailey, F.R.C.S. (Eng.). 8th ed. Pp. 336. Baltimore, William Wood, Williams & Wilkins Co. 1942. \$7.00.

**AMBASSADORS IN WHITE; the story of American Tropical Medicine.** By Charles Morrow Wilson. Pp. 372. New York, Henry Holt & Co. 1942. \$3.50.

**CABOT AND ADAMS PHYSICAL DIAGNOSIS.** 13th ed. Edited by F. Dennette Adams, M.D. Pp. 888. Baltimore, Wm. Wood, Williams & Wilkins Co. 1942. \$5.00.

**STEDMAN'S PRACTICAL MEDICAL DICTIONARY.** 15th ed. rev. by Stanley Thomas Garber, B.S., M.D. Pp. 1257. Baltimore, Wm. Wood, Williams & Wilkins Co. 1942. \$7.00.

**CARE OF THE AGED (Geriatrics).** By Malford W. Thewlis, M.D. 4th ed. St. Louis, C. V. Mosby Co. 1942. \$7.00.

**AMERICAN PHARMACEUTICAL ASSOCIATION. NATIONAL FORMULARY.** 7th ed. Official from Nov. 1, 1942. Pp. 690. Washington, D. C. American Pharmaceutical Assn. 1942.

## BOOK REVIEWS

**Microbes Which Help or Destroy Us.** By Paul W. Allen, Ph.D.; D. Frank Holtman, Ph.D., and Louise Allen McBee, M.S. Pp. 540. St. Louis, C. V. Mosby Company. 1941. \$3.50.

The popular demand by the laity for information about bacteria is met in this 530-page volume. It is written by teachers in bacteriology in the University of Tennessee. The authors have written the text in simple language, making it readable by lay persons. If the contents were fully digested by physicians they will have refreshed their knowledge of the mysteries of bacterial life.

The book provides pleasant reading, besides being educational. It will be a valuable addition to the teachers' shelves in undergraduate schools. Each chapter will furnish material for lectures and classroom work.

Readers with an omniverous thirst for knowledge will prize this volume.

H. A. TARBELL.

**Serology in Syphilis Control; Principles of Sensitivity and Specificity with an appendix for health officers and industrial physicians.** By Reuben L. Kahn, M.S., D.Sc. Pp. 206. Baltimore, The Williams & Wilkins Co. 1942. \$3.00.

In "Serology and Syphilis Control" one of our leading serologists and the inventor of one of the most widely used blood tests for syphilis, Dr. R. L. Kahn discusses the rôle of sensitivity and specificity in the development of the serodiagnostic test for syphilis. It is the belief of the author that "the better understanding of these fundamentals will mean the better utilization of these tests in the diagnosis and treatment of syphilis". Much of the material for the book has been drawn from studies made with the Kahn test.

According to Dr. Kahn, results obtained at the present time indicate that the perfect serodiagnostic test for syphilis has not, as yet, been discovered. The blood tests in use today do not detect all cases of syphilis and, to a varying degree, yield false reactions with normal sera. In other words, the goal of 100 per cent sensitivity and 100 per cent specificity has not yet been attained. With the blood test being used as never before it is obvious that the indiscriminate choice of a non-specific test

could be very dangerous. As there is some evidence in support of the presumption that increased sensitivity tends toward decreased specificity, all serologic tests should be evaluated at this time and a level of sensitivity adopted which would assure maximum specificity.

MEYER A. LEVY, B.Sc.

**Trauma and Disease.** Ed by Leopold Brahdy, B.S., M.D., and Samuel Kahn, B.S., M.D. 2d ed. Pp. 655. Philadelphia, Lea & Febiger. 1941. \$7.50.

Because of its concise, able and comprehensive treatment of the subject involved, this book certainly should prove an invaluable aid to every person interested in industrial problems arising from trauma. Written by specialists in each field, its clear treatment of the subject lends itself to a more definite understanding of trauma and its associated problems. The chapter which opens the book and written by its authors gives the conditions which control trauma and disease.

The fact that it has received recognition in the compensation courts of this state as a reference should be indication enough of its merit.

This reader believes that this work definitely constitutes a worthy addition to the shelf of the well-informed medical man and lawyer alike.

H. T. H.

**Manual of Standard Practice of Plastic and Maxillofacial Surgery.** Prepared and edited by the Subcommittee on Surgery of the Division of Medical Sciences of the National Research Council and Representatives of the Medical Department, U. S. Army. Robert H. Ivy, Chairman. Pp. 432. Philadelphia, W. B. Saunders Co. 1942. \$5.00.

This volume is one of a series of military surgical manuals and represents an attempt to standardize more or less the management and operative repair of plastic and maxillofacial cases. The authors have very wisely refrained from describing obsolete procedures which possess only historic interest and have adapted a positive policy of instruction.

The organization of subject matter is excellent and the operative repairs advised are sound proce-



dures. Naturally, emphasis is placed on war injuries and congenital deformities such as hair lip and cleft palate are not included. The book represents the best general plastic surgical text thus far written and will be valuable as a guide for every surgeon doing this type of work.

LYNDON A. PEER.

**Pediatric Gynecology.** By Goodrich C. Schauffler, A.B., M.D. Pp. 384. Chicago, Year Book Publishers, Inc. 1942. \$5.00.

A book which discusses immature female genitalia in specific detail is unusual and merits attention. The language is simple and concise. The chapter on the external genitalia includes the valva, clitoris, circumcision, masturbation, etc.; is well written and every physician examining adolescent girls ought to read it. The chapter on disorders during adolescence is instructive and answers very fully most of the questions that doctors are asked at this time. There are also special chapters on urologic and proctologic considerations and the medical, legal, social and psychological problems are fully discussed. The illustrations are numerous and very clear.

All in all, this is a book that ought to be in every practitioner's library.

CARL H. ILL.

**Night of Flame.** By Dyson Carter. Pp. 337. New York: Reynall & Hitchcock, Inc. 1942. \$2.50.

This is a pernicious story professing to portray the complex conditions one finds in a large hospital, about which a lay person does not have first-hand information. Such stories can do more harm in a few months than conscientious physicians in practice can offset in years of hard and unselfish work. Being written as a story, it will reach more uninformed people than if it had been presented in a less emotional form.

The right to use an M.D. after his name does not automatically turn one into an omnipotent being nor deprive him of the privilege of living as a human being as do other mortals. This book is just another exploitation of the profession without any recompense.

M. V. N.

**Carcinoma and Other Malignant Lesions of the Stomach.** By Waltman Waters, B.S., M.D., M.S. in Surgery, D.Sc., F.A.C.S.; Howard K. Gray, B.S., M.D., M.S. in Surgery, F.A.C.S.; James T. Priestley, B.A., M.D., M.S. in Experimental Surgery, Ph.D. in Surgery, F.A.C.S., and associates in the Mayo Clinic and Mayo Foundation. Pp. 576. Philadelphia, W. B. Saunders Co. 1942. \$8.50.

Drs. Waters, Gray and Priestley, with the help of their associates of the Mayo Clinic, have written an excellent monograph on carcinoma of the stomach. An analysis of almost eleven thousand cases made with such care must be an outstanding contribution, particularly when more than 90 per cent of the patients were traced for more than five years

and over 98 per cent of the eligible patients for longer than twenty years.

This itself is an astonishing achievement and has made possible certain conclusions regarding survival. When plotted against that of the normal population, the survival rate of patients living after five years is almost parallel. In other words, life expectancies of patients with resectable lesions approach normal after five years. Twenty-five per cent of all patients observed had resectable growths, and slightly less than 30 per cent of these were alive after five years. Thus, less than 8 per cent of all patients observed were alive after five years, their growth having been removed. When it is realized that 51 per cent of the patients had their symptoms for more than one year before operation, one of the reasons for the small number of survivals at once becomes apparent, as does also the possibility of improvement in this direction. The effect of the grade of malignancy on survival seems to be noticeable, the five-year survivals for grades 1 and 2 being three times those for grade 4. The survival rates after five years for all types approaches normal, as would be expected from the total resection survival chart.

To relate the interesting features of this book would be to present an abstract, and this would largely rob one of the great pleasure which is the reward for reading this book from cover to cover. It is refreshing to note the participation and contribution of a statistician in this work.

This book on carcinoma of the stomach should be in the library of every physician who comes into contact with this disease, regardless of his specialty.

C. ABBOTT BELING.

**Clinics.** Vol. 1, No. 1. June 1942. Edited by George Morris Piersol, M.D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, with the collaboration of various distinguished authors. J. B. Lippincott Co., Philadelphia, Pa. \$12.00 per year. Published bimonthly. Successor to The New International Clinics.

The appearance of "Clinics" as a successor to The New International Clinics, which has enjoyed a long run through the years, is a welcome one.

In this reviewer's opinion, the change in policy will not only renew interest in the publication but will also bring before the profession many worthwhile symposia on important subjects.

The first volume, with its distinguished symposium on burns and shock, sets a mark at which future issues may aim. Of particular interest is the plasma protein-deficit chart and the article on the use of plasma in burns by Rhoads, Wolff, Saltonstall and Lee. A review of recent progress in the responses of the peripheral blood vessels in man to various drugs by David Abramson is well placed as a companion to the papers on shock.

If the Board carries out the program outlined, the future of this publication would seem to be assured.

C. ABBOTT BELING.

# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

September, 1942

No. 9

INDUSTRIAL health and tuberculosis in industry are topics of great concern to all nations at war. Britain, the senior partner of the United Nations by length of service, was confronted much earlier than we were by problems arising from the conversion of peace economy to war production. The following are abstracts from recent British publications.

### INDUSTRIAL HEALTH

The recent reformation which has taken place in the health and life of the industrial worker in Britain is one of the most impressive and remarkable chapters in the progress of preventive medicine. It records a development from disorder, neglect and confusion to regularity and discipline, and from arbitrary mismanagement to scientific planning. It has become physiological, social and personal in objective. This is of national importance, for it affects five or six million men and women workers in the factories, and twenty million workers outside them. It sets a standard for all employment, and crystallizes British conceptions and traditions. It is perhaps the most popular of all public methods of preventive medicine, and has in it the elements of a liberal education. It improves and fortifies the individual health

of the workman—his only capital—increasing his dividend, lengthening his life and enlarging his opportunity and personality. It affects the whole man—his habits and character, his domestic life, his family and his home as well as his workplace. It is a great school of citizenship and health education of body, mind and spirit.

*The worker himself, and not his factory environment, is the vital factor.* His fitness, capacity, endurance and willpower are the chief requirements in order to prevent that overstrain, fatigue and disharmony which may be the precursor of disease. This is the center of gravity.

*Industrial Health, Sir George Newman, Britain Today, Feb., 1942.*

### THE TUBERCULOUS IN INDUSTRY

For years the after-care attention meted out to post-sanatorium cases has been the *Cinderella of the Tuberculosis Service*. This has been due to a variety of reasons. In the main, the results were less spectacular than those of the operating theatre and hence never achieved the same popularity in the lay mind; and again with a floating peace-time unemployed population of about three million, healthy labor was at a premium.

Information about tuberculous disease or previous treatment at a sanatorium or dispensary should be made compulsory for all persons entering industry. This is the practice at military boards and there appears no legitimate reason why this should not be incorporated into the civilian industrial life of the country. Such a measure would ensure the control of infection in the inter-

ests of the health of the community. Naturally, such a course will occasion opposition. It will be argued that this represents an encroachment on the freedom of the individual; however, freedom would be an intolerable institution if it permitted an individual indiscriminately to infect with disease his fellow creatures.

An extremely strong case can be made out in view of the recent extension of the defense orders making the treatment of scabies compulsory in the interests of national health. The extension of such a defense regulation to incorporate tuberculosis should prove a relatively simple legal measure.

*Some Reflections on the Tuberculous in Industry, Bertram Mann, M.B., Tubercle, March 1942.*

## MASS RADIOSCOPY IN FACTORIES

Much has been written lately concerning the value of mass radiography of the chest, and reports, among others, of investigations into the pulmonary pathology of Australian recruits, British sailors and University College Hospital students are available, but so far little has been done in this country with the ordinary unselected civilian population. Anyone who has felt the urge to conduct such an examination must at once have become conscious of the many difficulties, of which lack of suitable apparatus and the reluctance of the population to submit to examination are the chief. Nevertheless, few of us doubt that these difficulties will soon be overcome.

X-ray screening of the chest was offered to the work-people in two factories, the management allowing this to be done in working hours. In the first, 60% and in the second, 97% came for examination. Of 575 people examined in the first factory, three were found to be tuberculous. Of 795 examined at the second factory, two were known to have phthisis and two others were found to have active disease.

*Mass Radioscopy in Factories—Two Small Surveys, A. Stephen Hall, M.B., The Lancet, Feb. 7, 1942.*

## WEEDING OUT TUBERCULOSIS

Commenting on the above article by Dr. A. Stephen Hall, a later issue of *The Lancet* states in an editorial:

"In each factory about 0.5% of the workers had clinically significant tuberculosis. This percentage is lower than that found in similar mass surveys elsewhere, a common figure being between one and two per cent. The question therefore arises whether the examiner sees as much and as truly on the fluorescent screen as on the developed film.

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*Weeding Out Tubercle, Editorial, The Lancet, March 21, 1942.*

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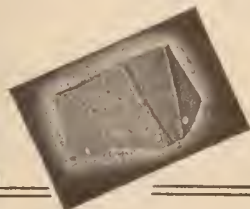
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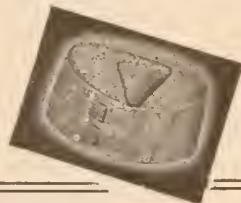
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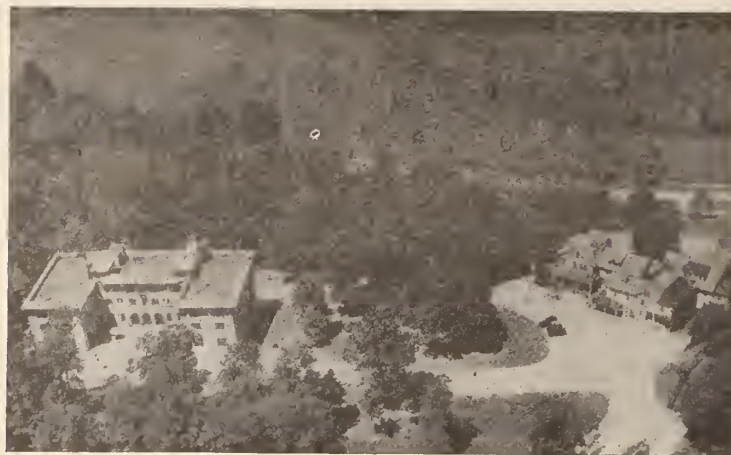
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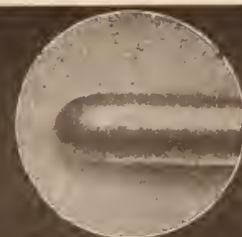
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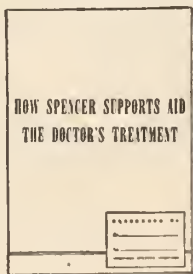
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### CONTENTS—Pages 517-566

#### EDITORIALS—

	Page
PRESIDENT'S MESSAGE—COMMITTEE WORK FOR THE YEAR .....	517
MEMBERS NOW IN WAR SERVICES .....	518
OUR BIG CHANCE .....	518
PHYSICIAN EXAMINE THYSELF .....	518
DO WE WANT GOVERNMENT CO-OPERATION OR CONTROL? .....	519
TEMPORARY LICENSES TO PRACTICE THE HEALING ART IN THE DISTRICT OF COLUMBIA .....	520

#### THE WAR—

Procurement and Assignment .....	521
Internships and/or Residencies .....	521
Physicians in Industrial Medicine .....	522
Find Many Selective Service Rejectees Can Be Rehabilitated .....	523
Army-Navy "E" Given Red Cross Blood Donor Service .....	523

#### ORIGINAL ARTICLES—

NEUROSES AND PSYCHOSES IN WARTIME—Clarence M. Trippe, M.D., F.A.C.P., Asbury Park, N. J. ....	524
NOCTURNAL ANGINA, A SYMPTOM OF CORONARY INSUFFICIENCY—Benjamin Rubin, M.D., South River, N. J. ....	529
THE INDICATIONS FOR SPLENECTOMY IN GAUCHER SPLENOMEGALY—Abraham O. Wilensky, M.D., New York, N. Y. ....	531
A NEW USE FOR WANGENSTEEN SUCTION DRAINAGE—C. Richard Weinberg, M.D., and Irving L. Sperling, M.D., Newark, N. J. ....	538

#### ORIGINAL ARTICLES—

MATERNAL MORTALITY STATISTICS IN NEW JERSEY FOR 1941. Maternal Welfare Article No. 74—Arthur W. Bingham, M.D., F.A.C.S., East Orange, N. J. ....	539
A LESSON FROM A DEATH CERTIFICATE .....	547

#### EXECUTIVE OFFICER'S PAGE

548

#### STATE ACTIVITIES—

Advisory Committees and Personnel .....	549
Scientific Work Committee .....	549
Trustees' Meeting .....	550
Welfare Committee Meeting .....	550
Industrial Medicine .....	552
With New Jersey Medical Authors .....	553
Study of New Jersey's Health Needs and Organization .....	553
Ill Resolution and Acknowledgment .....	554
Medical Care of Wives and Children of Enlisted Men .....	554
Quinine Restrictions .....	555
Newark Offices of The Medical Society .....	555
Members Serving in the Armed Forces .....	555
Supplementary List of Members .....	556

#### BULLETIN BOARD

557

#### COUNTY SOCIETY MEETING DATES

559

#### COUNTY SOCIETY REPORTS—

Bergen, Burlington and Gloucester .....	560
Hudson and Ocean .....	561

#### THE BOOK SHELF

562

#### TUBERCULOSIS ABSTRACTS

565

Roster of Officers, Advertising Page 3a

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JOSEPH F. LONDRIGAN .....Hoboken  
SAMUEL ALEXANDER .....Park Ridge  
ALFRED STAHL .....Newark  
GEORGE J. YOUNG .....Morristown  
E. ZEH HAWKES (1943) .....Newark

J. HOWARD HORNBERGER (1943) .....Roebling  
ANDREW F. MCBRIDE (1943) .....Paterson  
JESSE MCCALL (1943) .....Newton  
WILLIAM F. COSTELLO (1944) .....Dover  
GEORGE W. FITHIAN (1944) .....Perth Amboy  
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### Delegates

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### Alternate Delegates

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LANCELOT ELY (1944) .....Somerville  
CLARENCE W. WAY (1944) .....Fort Tilden, N. Y.  
SPENCER T. SNEDECOR (1943) .....Hackensack  
RALPH K. HOLLINSHED (1943) .....Westville



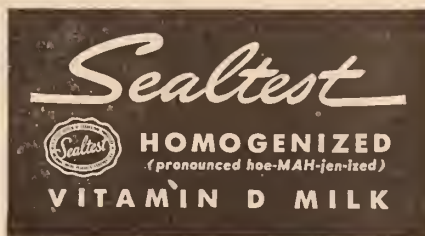
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W. S. McClellan, M. D., Medical Director, Saratoga Spa,  
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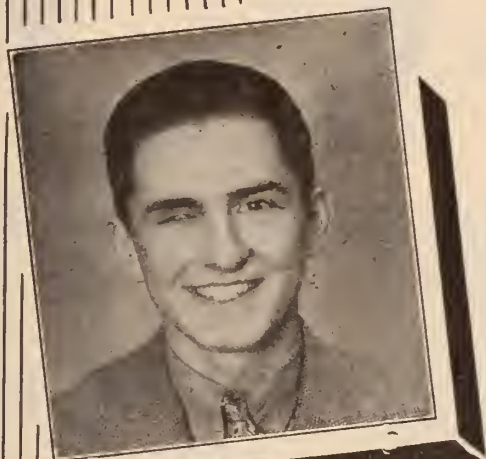


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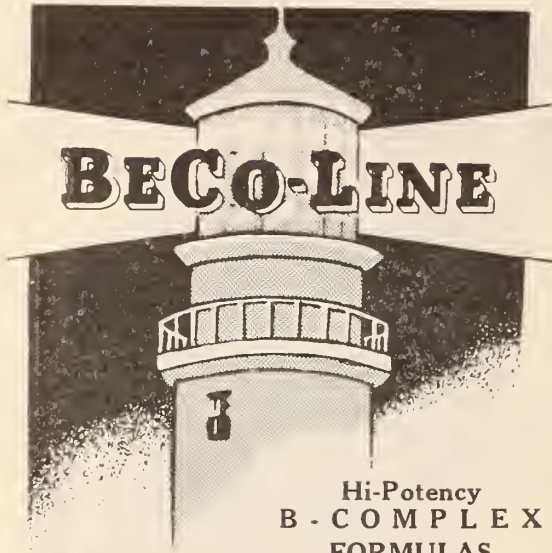
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**B<sub>1</sub>** . . . 30 mg.; **B<sub>2</sub>** . . . 0.5 mg.; **B<sub>6</sub>** . . . 2 mg.  
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10 mg. *Supplied:* 10 cc. vials.

### BeCoPlex

Hi-potency per tablet:

<b>B<sub>1</sub></b> (Thiamine) . . . . .	3 mg.
<b>B<sub>2</sub></b> (Riboflavin) . . . . .	2 mg.
<b>B<sub>6</sub></b> (Pyridoxine) . . . . .	1 mg.
<b>Niacin</b> . . . . .	20 mg.
<b>Pantothenic Acid</b> . . . . .	5 mg.

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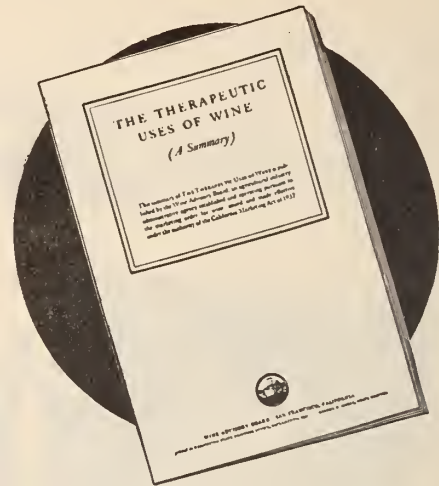
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**Ferric Phosphate** is a proven utilizable iron that does not destroy the B factors in combination.

BeCoPlex and BeCoFerric tablets are supplied in bottles of 50, 100, 500, 1000; and for Industrial use in handy, pocket-size, non-breakable, bakelite vials of 14 tablets (a two weeks supply).

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*Food Company*  
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*Published by the Wine Advisory Board*

## THE THERAPEUTIC USES OF WINE

*(mailed free upon request)*

There has developed an interest within the medical profession that the true physiologic and therapeutic uses and deficiencies (and also the food values) of wine be authoritatively reviewed. Such a review has been prepared in monograph form by qualified and competent medical authorities and constitutes a summary of the pertinent scientific literature of present-day medicine.

The contents include sections on wine as a food, and the actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are also discussed. The value of wine as a vehicle for medication is dealt with, and an important section on the contraindications to the use of wine is included. An extensive bibliography is presented for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.



THE NEW APPROACH TO ADJUSTMENTS IN

# Smoking Hygiene

- The new opportunity for patients' cooperation
- The value of keeping special case histories



THE relationship of nicotine intake to certain sub-clinical symptoms is of interest to the physician.

Time was when clinical observation in such cases was difficult. Patients were reluctant to fall in with limitations on smoking.

Now your recommendation of slow-burning Camels\* is a simple step towards securing this cooperation. Millions have found an added "pleasure factor" in Camel's special mildness and unusually fine taste.

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\**The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941  
*J.A.M.A.*, 93:1110—October 12, 1929

Brückner, H.—*Die Biochemie des Tabaks*, 1936

★

"THE CIGARETTE, THE SOLDIER, AND THE PHYSICIAN," *The Military Surgeon*, July, 1941. Reprint available. Write Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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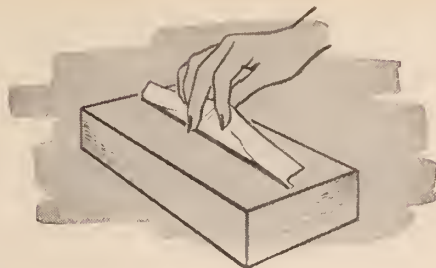
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is quickly relieved by the sustained vasoconstrictive  
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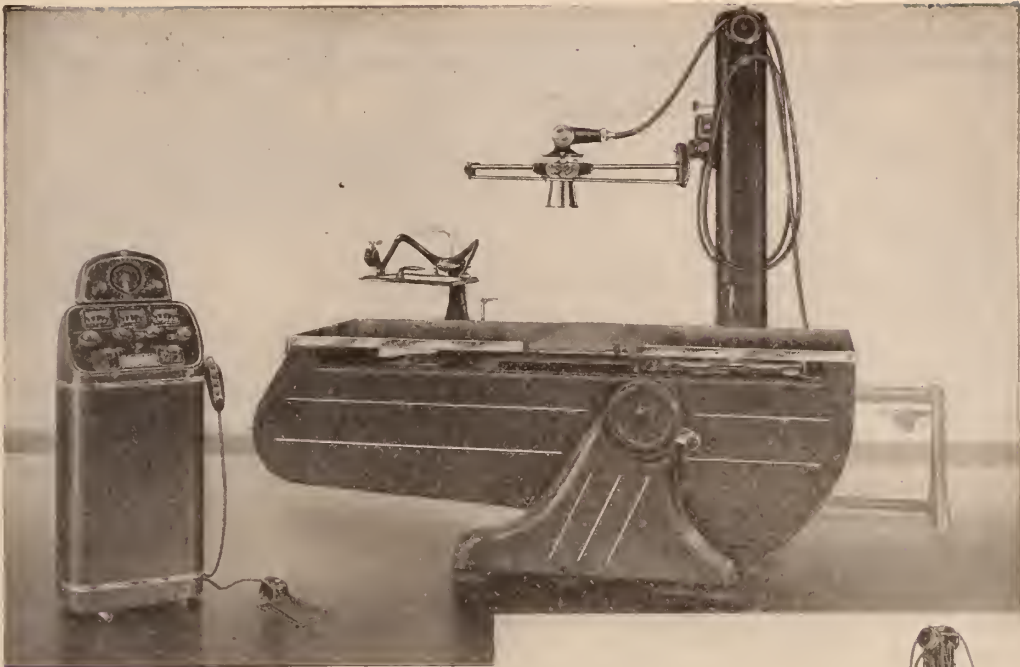
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are set down  
on prescriptions  
for pharmaceuticals  
more often . . .  
none inspire  
greater faith  
in their merit  
than . . .







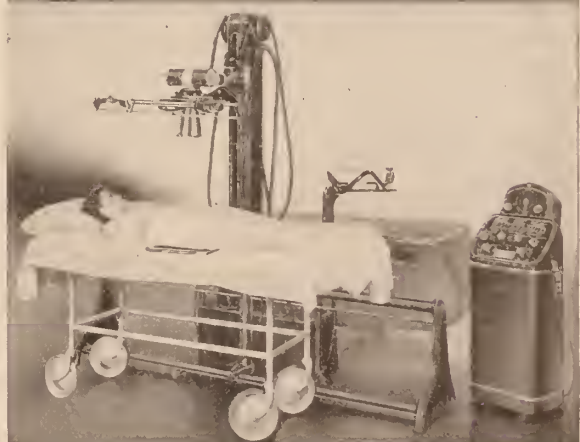
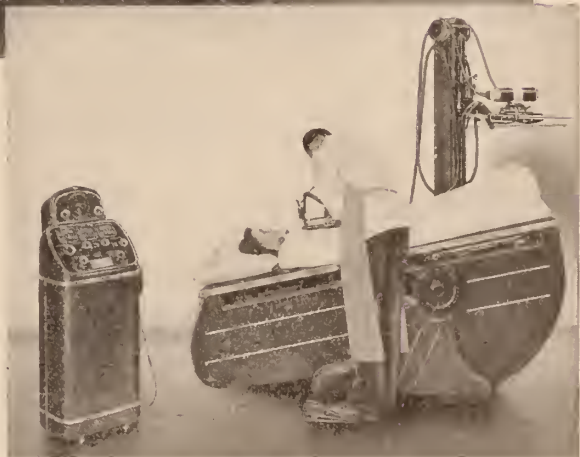
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# Walker-Gordon Homogenized Soft Curd Milk

IN RESPONSE to widespread suggestion on the part of physicians and consumers alike, Walker-Gordon has now developed a homogenized soft curd milk of exceptional purity and digestibility.

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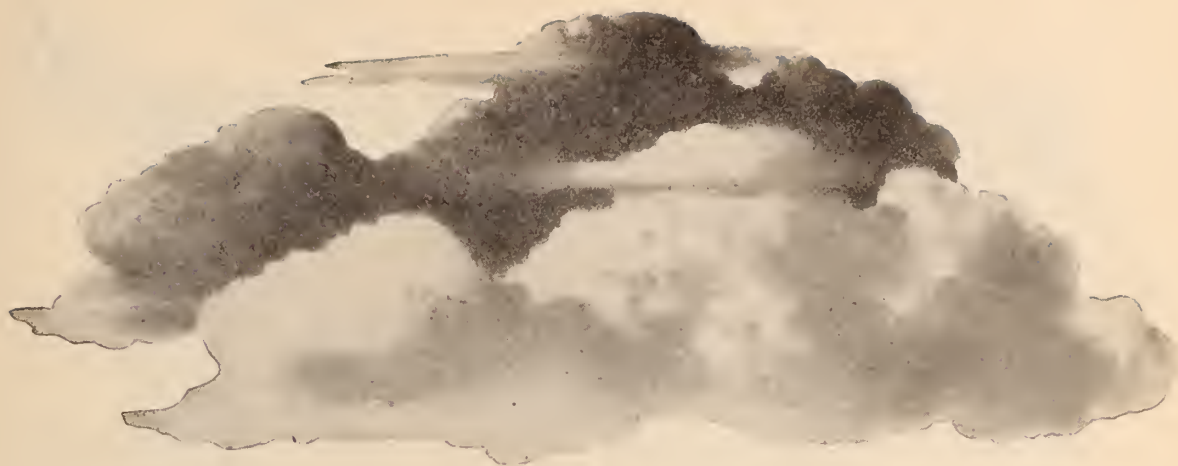
It is now available through all leading milk distributors in New Jersey area.

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THE WORLD'S FINEST MILK

AVAILABLE EITHER UNHEATED, PASTEURIZED, OR HOMOGENIZED

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## When depression accompanies more fundamental pathology

In many patients, depression may occur as an accompaniment of some more fundamental pathology, either organic or psychogenic. In such cases, the physician should bear in mind that, while Benzedrine Sulfate will not affect the underlying condition, its stimulatory effects may help to alleviate the concomitant depression which so often interferes with the management of the case.



## Benzedrine Sulfate Tablets

Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

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- LOW IN TOTAL SOLIDS
- EXCEPTIONALLY CLEAR

IN PERNICIOUS ANEMIA, Liver Extract in adequate dosage will produce a prompt reticulocyte response and hematologic recovery. Once dosage requirements have been established and the blood picture returned to normal, administration may be reduced to two- or three-week intervals.

Concentrated Liver Extract Squibb (15 units injectable per cc.) offers the advantages of being low in total solids, and exceptionally clear and light colored. Its high concentration affords low dosage volume and may save the patient considerable discomfort. Furthermore, cost of maintenance is appreciably less than with effective doses of liver principle given orally. It is available in 3x1-cc. vial packages and in 5-cc. and 10-cc. vials.

Liver Extract Squibb is a sterile, aqueous solution, obtained from edible liver. Both the regular and concentrated potencies are standardized on the basis of the hematopoietic response in pernicious anemia as defined by the U.S.P. Anti-Anemia Preparations Advisory Board. This Board has ruled that at present a strength greater than 15 units per cubic centimeter will not be assigned to a preparation because of the possibility of loss, during the concentration process, of unknown factors of value in the treatment of patients with pernicious anemia.\*

Solution Liver Extract Squibb (3.3 units injectable per cc.) is especially prepared. It is *not* made by diluting Concentrated Liver Extract. It is available in 10-cc. vials.

\* N. N. R. 1941, p. 328.

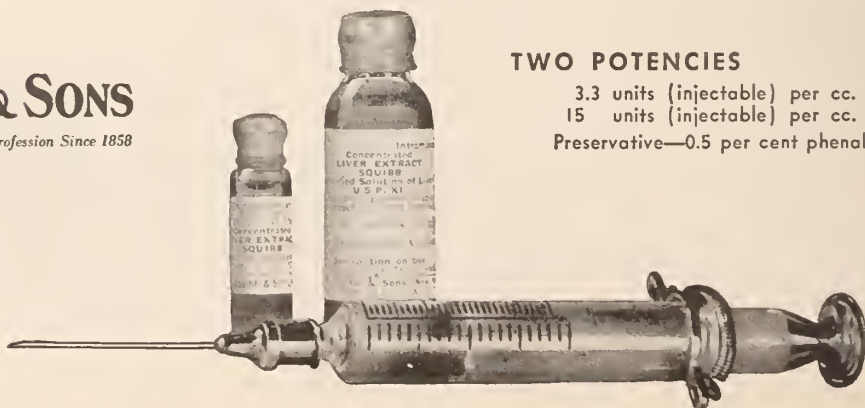
For literature address Professional Service Department, 745 Fifth Ave., New York, N. Y.

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### TWO POTENCIES

3.3 units (injectable) per cc.  
15 units (injectable) per cc.  
Preservative—0.5 per cent phenol







## Why Biolac plays an important part in wartime practice

**I**N THESE DAYS of overwork, you need every minute you can get.

Biolac, because it is a *complete* infant formula, is an important timesaver for many doctors. It saves valuable time in computing feeding directions.

Biolac provides completely for all the nutritional requirements of the normal infant *except* Vitamin C. And it supplies all these food elements in amounts that equal or exceed recognized requirements for optimal growth and health. (See chart below.)

Not only can Biolac save you sorely needed time, Biolac formulas are so simple to prepare—requiring only dilution with boiled

water as you prescribe—that the busy mother's formula-mixing time is cut to a fraction, as are chances of formula errors and contamination.

For professional information about Biolac, write Borden's Prescription Products Division, 350 Madison Avenue, New York, N. Y.

• *Biolac is prepared from whole milk, skim milk, lactose, Vitamin B<sub>1</sub>, concentrate of Vitamins A and D from cod liver oil, and ferric citrate. It is evaporated, homogenized, and sterilized.*



## NO LACK IN BIOLAC

Borden's complete infant formula

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PROTEIN (gms./lb. body weight) . . . . .	1.4 to 1.8	2.2
CALCIUM (gms./day) . . . . .	1.0	1.0
IRON (mgms./100 calories) . . . . .	0.75	1.25
VITAMIN A (U.S.P. Units/day) . . . . .	1500.	2500.
VITAMIN B <sub>1</sub> (U.S.P. Units/day) . . . . .	83.	85.
VITAMIN B <sub>2</sub> (mgms./day) . . . . .	0.5	2.
VITAMIN D (U.S.P. Units/100 calories) . . . . .	50.	63.

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(Acetyl-Beta-Methylcholine Chloride Merck)

administered by the method of Ion Transfer  
(Iontophoresis)

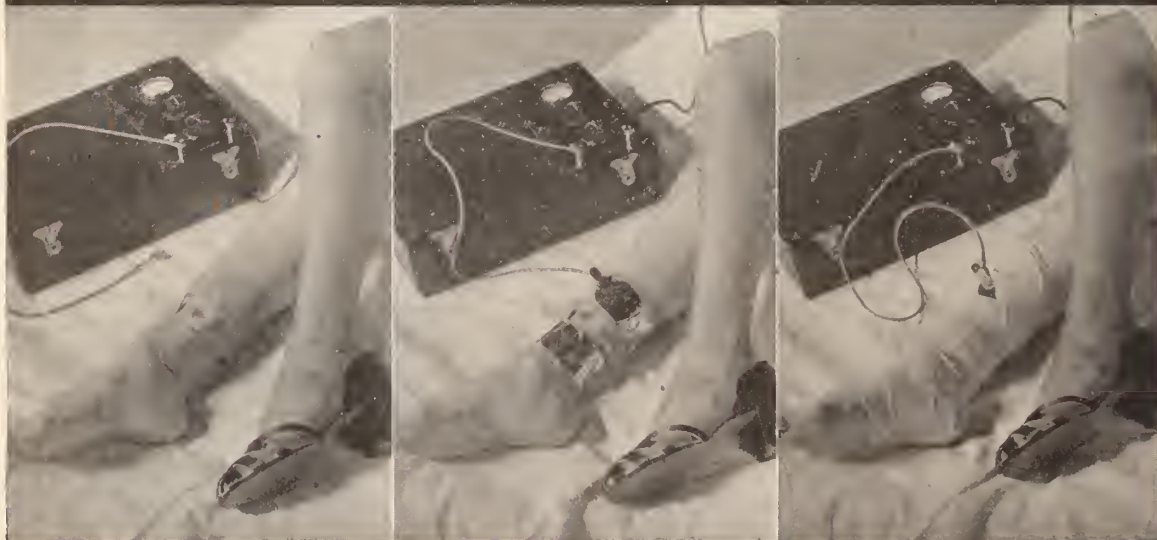
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Of service in the treatment of  
Vasospastic Conditions of the Extremities  
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## ION TRANSFER — TECHNIC OF APPLICATION



Reinforced asbestos paper applied

Electrode placed over paper

Fully bandaged

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# COMMANDO RAID!



Commando raids are dramatic and do their share in helping us win the war. Less spectacular, but equally important to Victory, is the role of nutrition in building a strong hard-hitting America.

COCOMALT, the enriched food drink, is doing its part in the all-out effort toward better states of nutrition. For, COCOMALT contains vitamins A, B<sub>1</sub>, D and the minerals calcium, phosphorus and iron . . . all essential factors in well-balanced diets.

More and more physicians are recommending this delicious food drink for the entire family. The rich, full flavor of COCOMALT, either hot or cold in milk, is a delightful drink for those who will not ordinarily drink milk alone.



## Cocomalt

ENRICHED FOOD DRINK

R. B. DAVIS COMPANY, Hoboken, N.J.



## Will smallpox continue to decline in 1942?

## SMALLPOX VACCINE

*Lederle*

THE new "low" in smallpox incidence reached in this country in 1941 compares most favorably with the perennially high incidence reported in previous years:<sup>1</sup>

	Median
	1936-40
1941	
SMALLPOX . . . . .	9,574
1,368	

However, we are still far too tolerant of this dangerous disease.

To avert the possible increase in the incidence of infectious diseases, which history has shown is fostered during war time, our government recently made the commendable move of advising the immunization of all children over 6 months of age against smallpox. The success of this program, however, depends on the cooperation of every practitioner, public health official and local governing body alike.

TOOMEY,<sup>2</sup> in a recent analysis of active immunity in smallpox, stressed the integrity of the immunizing agent and the proper technique of vaccination. Lederle now has available "Smallpox Vaccine Lederle" which has been further improved by the addition of Brilliant Green (reducing the bacterial count of the virus). The "take" with this product is quite satisfactory and its viability has not been diminished as compared with glycerinated vaccine cured without the dye.

<sup>1</sup>Pub. Health Rep. 57:23,24 (Jan. 2) 1942.

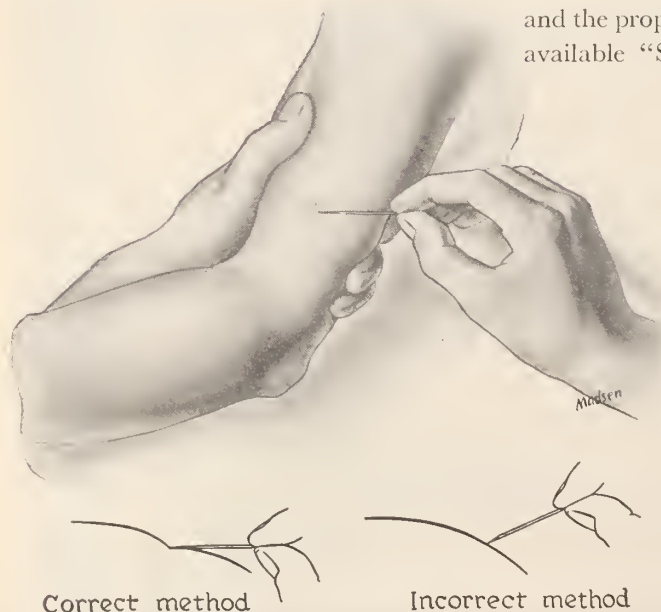
<sup>2</sup>TOOMEY, J. A.: J. A. M. A. 119:18 (May 2) 1942.

## PACKAGES

"Smallpox Vaccine Lederle" (U. S. P.)  
1, 5 and 10 vaccinations

"Smallpox Vaccine Lederle" (Preserved with Brilliant Green)  
1, 5 and 10 vaccinations

*Supplied in glass capillary tubes, with sterile steel needle for each vaccination.*



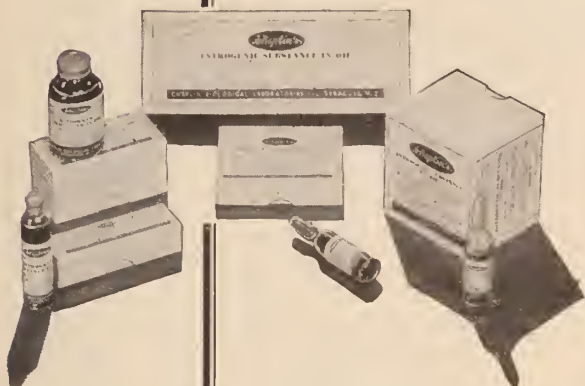
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2,000 Int. Units per c.c.	10,000 Int. Units per c.c.
5,000 Int. Units per c.c.	20,000 Int. Units per c.c.

Each strength is respectively furnished:

In 1 c.c. Ampoules....	6, 12, 25 and 100 per box
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In 30 c.c. Vials.....	1 vial per box

*Write for Catalog and Prices*

Cheplin ampoules and other biological products are built up to an "Accepted" standard — not down to a low price—THE HIGHEST OF QUALITY AND PURITY, YET ECONOMICAL IN PRICE.



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That PHILIP MORRIS are less irritating to the nose and throat is not a claim. It is the result of a difference in manufacture, *proved*\* advantageous over and over again.

But why not make your own tests? Why not try PHILIP MORRIS on your patients who smoke, and *confirm* the effects for yourself.

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119 FIFTH AVENUE, N. Y.

\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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**TO PHYSICIANS WHO SMOKE A PIPE:** We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.





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*are U.S. Gov't Grade!*

• Tomatoes that make the grade for Kemp's Sun-Ray Brand Tomato Juice have to pass a rigid "physical" exam. A U. S. Gov't inspector checks their color, degree of ripeness, freedom from defects. You might think these tomatoes too fine for juice! But in they go—all the tender solids of the whole tomato utilized by Kemp's patented process No. 1746657, for high retention of vitamins A, B<sub>1</sub> and C. That's why this juice is so gloriously good, with color that never separates, and consistency that is never thin or watery. You can recommend Kemp's Sun-Ray Brand Tomato Juice with confidence.

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**NON-SEPARATING**



# *Highly Active* BACTERIOSTATIC AGENT

Sulfathiazole exerts a prompt bacteriostatic effect upon a number of pathogenic organisms. A pronounced action is observed on the following:

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GONOCOCCUS • MENINGOCOCCUS

Remarkable clinical results have been consistently obtained in infectious conditions caused by these organisms. Complications which are commonly encountered in pneumonia, gonorrhea or meningitis are greatly reduced in frequency and severity.

The dosage should be adjusted to the nature of the disease, as well as to the age and condition of the patient. Write for dosage chart and booklet on Sulfathiazole-Winthrop.

Sulfathiazole-Winthrop is supplied in tablets of 0.5 Gm. (7.72 grains), bottles of 50, 100 and 500; also (primarily for children) in tablets of 0.25 Gm. (3.86 grains), bottles of 50, 100 and 500. Sterile powder is available in bottles of 5 Gm.,  $\frac{1}{4}$  lb. and 1 lb.



## *Specify* SULFATHIAZOLE *Winthrop*



*Winthrop* CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician

NEW YORK, N. Y. WINDSOR, ONT.

# “Vision for Victory”

The Better Vision Institute will conduct a tremendous advertising campaign during the next year—with full pages in “Life”, “Saturday Evening Post”, “Collier’s”, “Time”, “American”, and “Nation’s Business” using the above theme “Vision for Victory”.

It is logical to expect that from a campaign of such magnitude, your patients will be seeking advice from you. **PLAY SAFE**, send them to your colleague the **EYE PHYSICIAN** for an eye examination—and if glasses are necessary, then to a **GUILD OPTICIAN**.



## Guild of Prescription Opticians of New Jersey, Inc.

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HENRY A. DAVIDSON, M.D., Editor  
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## PRESIDENT'S MESSAGE

### COMMITTEE WORK FOR THE YEAR

The appointment of committees for the present administrative year has been attended with grave difficulties, resulting from the departure of many experienced chairmen and desirable members for service in the armed forces of the nation, and the consequent increased load on those remaining at home. It is realized that this shortage of available man-hours and of gas and rubber for transportation will necessitate a considerable curtailment of the committee work in comparison with the achievements of recent years. To compensate in part, some of the least urgent committees have been retired to inactive status, and in the Subcommittee on Public Health the regular advisory committees have been reduced in membership, and a pool of liaison advisers of many types of practice has been established on which any chairman may draw for additional assistance. The work of

the regular standing committees will be so arranged as to demand as little as practicable of the members' time.

Some things, however, must go on if the Society is to operate; your officers are prepared to give of their time all that is necessary for this purpose, and they confidently expect that the members will do the same. We believe that our Society is a public service, in its own way, as much as the government agencies are in theirs, and must be equally provided for. We therefore bespeak the continued interest, and support with time and effort, of all the members in this difficult period of our history. Further announcements will be made from time to time about our efforts to adjust our hopes and ambitions to the facts of the ever-changing situation.

ELIAS J. MARSH, M.D., *President*,  
The Medical Society of New Jersey.

## MEMBERS NOW IN WAR SERVICES

On page 521 is an official statement from the Procurement and Assignment Office in Newark regarding New Jersey physicians now in Federal Service

The Medical Society of New Jersey has credited or refunded where dues had already been paid, the dues of members in Federal Services when due notification from the County Society had been officially made to the Executive Offices. The number to date is 616 members now in service. Judging from the figures submitted by the Procurement and Assignment Service for New Jersey, there are

probably more of our members in service who have not, through their County Societies, fulfilled the proper procedure to receive the credit or refund of their dues for the current year. Credits and refunds cannot be made until the proper procedure is fulfilled, so that when our books are audited the accounts will be properly accredited by the auditor.

Every member entering the service is urged to promptly notify the Executive Offices in Trenton and his County Society so that they may proceed in due order to report his entering the service to the Executive Offices.

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## OUR BIG CHANCE

An old and still often quoted saying which has stood the test of time is to the effect that "If you want to get a job promptly and well done, give it to a busy man." Wartime demands keep all competent physicians busy. However, there are needs which still must be met and Congress and the President have provided authority and funds for the government agencies to get the job done.

Some of these jobs include physicians' services. The members of The Medical Society are asked by the Bureau of Maternal and Child Health of the State Department of Health to assist for the emergency, to provide care for the wives and children of enlisted men who are serving with the Armed Forces of the

U. S. A. These men should not have to feel concerned about their dependents being cared for when they are in need of medical care and cannot pay for such service. The government will pay for such care and our Medical Society members have agreed to provide the service. This is our big chance to prove both our ability and our willingness to make good on that promise and show that we can *ourselves* do the job. If we do not do it we cannot blame the government for taking over the whole job. If we do a good job everybody, including government, will be pleased and will leave these medical jobs to us.

We are busy men—yes, but we can and will do this job too for Uncle Sam.

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## PHYSICIAN EXAMINE THYSELF

The question is often asked, "How may I know a good physician?" This is both a pertinent question and one difficult to answer satisfactorily. There are, of course, answers often given such as "Consult your County Medical Society," which are proper as far as they go, but not entirely adequate. It might be well

before we attempt to answer such an inquiry to ask ourselves "What is *essential* in a good physician?" We might then list among the requisites for a good physician the following specifications:

1. He shall have graduated from a medical school of unquestioned standing or reputation, one which will accept as



a student and graduate only well-prepared candidates with a proven and sustained interest in and attitude toward the profession and the public as would suggest a successful career in his chosen field.

2. His internship should have been spent in a hospital approved by the American Medical Association for internships, preferably a hospital where medical students come to receive clinical instruction. He should later have good hospital connections and be ranked therein, commensurate with his years of experience.

3. He should have an active public interest which results in his participation in community activities where his special contributions are such as to naturally increase the demand for his services in such capacity and as a practicing physician. His private patients should as a rule speak well of him as a professional and personal adviser. This will be most convincing proof of his fine character and personality.

4. The degree of care and accuracy he shows in all he does will be manifested in his speech, his appearance, his reliability as to appointments and the discharge of voluntarily assumed obligations. There are times when these may of necessity be broken, but such times are really relatively infrequent.

5. He listens attentively and patiently to his patient's story and complaints, tactfully keeping the pertinency and continuity of events and excluding the unconscious deviations followed by the patient in the telling. His questions are clear, concise, tactful and pertinent to his line of inquiry and aid the patient to

provide the data most helpful in his case to his physician and himself. The capable physician avoids leading questions which might prejudice the answers he receives from his patient.

6. He will have his emergency supplies complete and ready for use at all times and will get as much information from his patient's family over the phone as possible, directly or through his office nurse, before leaving his office, so he will be equipped for the *unusual* situation.

7. He will plan his work, schedule his time, keep his records and books up to date and be "on time" with the minimum of excusable exceptions, for the patient watches the clock when the doctor sets the hour of his call, and time drags for the patient until his physician comes.

8. As soon as the volume of his work justifies the investment, he will use nurses and technicians to keep down costs and relieve him of all but those activities which require his own individual and purely professional skills and knowledge. He will, however, never lose control and direction of all services rendered to the patient.

By this time the physician reader properly asks "How can a patient apply these tests to his physician?" and the answer is that he can only apply a few of them himself. The real purpose of this editorial is to provide a "quiz-test" which we as physicians can apply in the privacy of our homes or offices to ourselves as a sort of "yardstick" to measure our strength and weakness and thus give direction to our efforts at improvement of our service and ourselves.

N. B. The criteria used is, of course, not infallible.

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## DO WE WANT GOVERNMENT CO-OPERATION OR CONTROL?

Our members are advised to read in the September 12, 1942, issue of the Journal of the American Medical Association two very pertinent articles which are apt to be overlooked by those who

hastily glance through the Journal. The first is on page 137 under *Medical News* and is headed "Special News". It deals with the subject "Health Under Hitler". The first paragraph tells of the requis-

tioning of Norwegian hospitals for wounded German soldiers who are being transported to Norway, and the turning out of Norwegians to make room for the German soldiers. "Practically every hospital in the interior is requisitioned for the Germans, and the Norwegian patients are being sent to school buildings which have been prepared for them." The various other provisions for the wounded German soldier and the exclusion of other interests in his behalf, not only throughout German but through the German-dominated countries, is briefly mentioned in this interesting and important article, in which one can see the domination by the Nazi government not only of the medical practice but in almost every one of the aspects which we in America are free to enjoy as in the past. This *extreme* governmental domination is, of course, very exceptional, but shows the effects possible under such extreme governmental monopoly.

In contrast to this situation is the report of London under date of August 1, 1942, of the Medical Planning Committee of the British Medical Association. In this latter report emphasis is laid upon the fact that medical service has grown up without proper coördination and integration, which is essential between private practice, philanthropy and govern-

ment, since all three of these enter into the provision in what is known in its broader sense as medical service. One significant remark in this report is quoted. "It is generally agreed that the present system, or want of system, cannot last but there is much difference of opinion as to its reform." The Commission has now published an elaborate report, a copy of which has been ordered for the Executive Office.

The hospital services also are to be brought into a unified hospital system. One group of reformers in England demands a complete state-controlled hospital service, which presumably would absorb the great voluntary hospitals. Another group clings to nonprofit voluntary hospitalization under private control.

Each member is especially urged to read the proposals embodied in this report. This offers a most concrete and workable basis for medical service distribution at an economical cost to provide the widest benefits from the services of physicians who are the essential unit in any form of medical service that has been presented, and the proposal would bear close study and thought in our preparations for meeting the post-war medical service problems in this country.

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### TEMPORARY LICENSES TO PRACTICE THE HEALING ART IN THE DISTRICT OF COLUMBIA

Of interest, because of the precedent it establishes, is a bill introduced in the House of Representatives by Representative Randolph of West Virginia, relating only to the District of Columbia. It is an act to provide *temporary* permits to practice the healing art in the District of Columbia, valid for one year, renewable for a similar period and terminable automatically six months after the end of the present war.

In this connection physicians can take a note from the Nursing Organizations

who have insisted that, in order to preserve standards at an approved and safe level, any temporary aid shall come from those who are easily distinguished from the trained nurse whenever these "aides" are less adequately trained and are approved for emergencies, especially those confronting us in wartime. The specious argument of *emergency* is also being used as argument in favor of lowering practice requirements in the medical field and thus making less significant the M.D. degree.

# THE WAR

## PROCUREMENT AND ASSIGNMENT

The State Advisory Committee of Procurement and Assignment Service met on October 1, 1942, in Newark. The Officers of each of the New Jersey Physicians' Examining Boards were guests.

The membership of this Committee represents the Board of Trustees of The Medical Society of New Jersey, each Councilor District of the Society, the New Jersey Department of Health, the New Jersey Association of Industrial Physicians and the American College of Surgeons.

Officially, the Committee is advisory to the Federal Manpower Commission through Procurement and Assignment Service. It will assist New Jersey Procurement and Assignment Service in the interpretation of national procurement policies on State and local levels. The activities of the New Jersey Office will be guided by the advice of the Committee.

At the meeting of October 1st, the Committee reviewed all past activities of New Jersey Procurement and Assignment Service. It approved of the procedures which have been used by New Jersey Procurement and Assignment Service in enrolling physicians and considered many of the current medical problems affecting New Jersey hospitals, communities and industries.

By motion duly made and carried, the Committee recommended that each County Medical Society submit to the New Jersey Procurement and Assignment Office the names of all physicians, under 45 years of age, practicing in their respective counties, whom they considered as "available" for military service. The New Jersey Office of Procurement and Assignment Service will proceed on the basis of this recommendation.

A duplicate copy of the roster, submitted by the National Scientific Roster, of physicians in each county who signed and submitted a Procurement and Assignment Questionnaire, has

been forwarded to each respective County Society.

Records of this office show that 1553 physicians from New Jersey are now in Federal service. From this total should be deducted about 200, representing internes, who will not be credited toward our State quota.

The list by counties follows. We request that county Secretaries notify this office of any substantial errors in this report.

### NEW JERSEY PHYSICIANS IN FEDERAL SERVICE

COUNTY DISTRIBUTION	
Atlantic .....	71
Bergen .....	125
Burlington .....	30
Camden .....	87
Cape May .....	13
Cumberland .....	17
Essex .....	426
Gloucester .....	16
Hudson .....	183
Hunterdon .....	6
Mercer .....	81
Middlesex .....	50
Monmouth .....	68
Morris .....	35
Ocean .....	13
Passaic .....	122
Salem .....	5
Somerset .....	14
Sussex .....	7
Union .....	141
Warren .....	6
<hr/>	
Total by counties .....	1516
No county stated .....	37
<hr/>	
Grand total .....	1553

The above statement was provided by the Procurement and Assignment Service, Room 902, 31 Clinton Street, Newark, N. J., through the Secretary of the Committee on Procurement and Assignment, Norman M. Scott, M.D.

## INTERNSHIPS AND/OR RESIDENCIES

The directing board of the Procurement and Assignment Service has addressed the following memorandum to the administrators of all hospitals approved for internships and/or residencies:

1. In compiling lists consider only full-time staff members conducting essential hospital services (e.g. roentgenologist), visiting staff

members who actually conduct ward work, residents and interns.

a. Residents should be considered essential on the basis of general hospital work and not because of the service they render in the care of private patients, except as it contributes to their training.

b. Individuals who have completed one



year of internship shall be considered available for military service unless they are appointed to an essential position as a hospital resident.

2. Do not consider visiting or courtesy staff members who serve only private patients. Their essentiality will be determined by the local Procurement and Assignment committees on the basis of their services to the community as a whole rather than their need in any particular hospital.

3. The residency program must be drastically curtailed and the number of residents decreased in numbers.

4. Subsequent to July 1, 1942, and during the war emergency, designation of a man as an essential hospital resident or fellow should not exceed two years beyond the completion of one year's internship.

5. Having determined the minimum number of essential positions, these positions should be filled as far as possible by:

a. Women.

b. Young men physically ineligible for military duty and older men.

6. Visiting staff members should be asked to contribute additional hours to their duties in the hospital.

7. Routine work of residents and interns should be delegated as much as possible to qualified nonmedical personnel for clerical, laboratory and other services.

8. One copy of the revised hospital list should be sent to the state chairman of the Procurement and Assignment Service and one copy to this office within one week of the receipt of this letter. A sample form for this report is enclosed.

9. It is important that every hospital staff member be informed by the hospital as to classification as essential or available, subject to approval by the Procurement and Assignment Service.

10. Your continued coöperation in this effort on the part of the Procurement and Assignment Service to provide medical personnel for the armed forces and at the same time to maintain essential hospital services during the war will be appreciated.

A blank is provided on which hospital administrators are requested to furnish full information regarding all staff members.

Each hospital administrator has a definite responsibility to provide the necessary medical services for the patients of his hospital. In many hospitals, particularly those which care for charity patients and which are affiliated with medical schools, the retention of a minimum resident staff is essential both for the care of the patients and for medical education. Nevertheless, it is obvious that drastic reductions in the peacetime staffs of hospitals must be made if the needs of the armed forces are to be met.

## PHYSICIANS IN INDUSTRIAL MEDICINE

The situation regarding recruitment of physicians now employed in industrial medicine has caused the directing board of the Procurement and Assignment Service to send the following memorandum to all state chairmen relative to the methods by which the essentiality of physicians engaged in industrial medicine may be determined:

A physician employed in industry is deemed to be essential when the following conditions exist:

### A. Full-time industrial physician.

1. The physician is employed by an industry which is manufacturing war materials exclusively or under priority ratings, and
2. The physician gives his full time to the industry or forty or more hours weekly, has been so employed for at least two years, or is especially trained for that purpose and is carrying on an acceptable health maintenance program, and

3. The physician is performing the function of a medical director or department head or of a specialist or is the only physician employed.

4. Assistant physicians who perform routine functions under direction and are employed on a full-time basis are deemed essential until they can be replaced within a reasonable time (three to six months).

### B. Part-time industrial physician.

1. The physician serves part time two or more industries engaged exclusively in the manufacture of war materials or under priority ratings, provided his total part-time service is the equivalent of forty or more hours weekly. Note: The physician who serves on call only is not deemed to be essential.

C. The physician serves a state industrial hygiene bureau on a full-time basis.

## FIND MANY SELECTIVE SERVICE REJECTEES CAN BE REHABILITATED

**TWO-THIRDS OF THE REGISTRANTS IN TENNESSEE, AFTER CORRECTION  
AND TREATMENT, MAY BE AVAILABLE FOR SERVICE, SURVEY SHOWS**

An analysis of the results of physical examinations in Tennessee under Selective Service from February 15, 1941, to January 1, 1942, shows that "in considering possible manpower for military service, after correction and treatment possibly around two-thirds of the registrants in Tennessee may be made available," Harrison J. Shull, M.D., Major, M. C., U. S. Army; Joe W. Fenn, M.D., Major, M. C., U. S. Army; Ruth R. Puffer, and W. C. Williams, M.D., Nashville, Tenn., declare in a report published in the August 1 issue of *The Journal of the American Medical Association*. Their findings are based on the results of examinations on 47,880 registrants.

"Slightly over one-half (52.6 per cent) of these registrants were considered qualified for general military service," the investigators point out. "Of the 22,696 registrants not qualified for general military service, 20,497 were rejected by local boards and 2,199 by induction stations.

"Among the 43,034 registrants on whom serologic tests were made, 8.3 per cent were found to have syphilis, with the percentage of colored men (26.3 per cent) nearly ten times that of white men (2.7 per cent). The second most common among these diseases and conditions was musculoskeletal defects, causing 7.4 per cent of these men to be classed I-B or IV-F. Other very prevalent defects were teeth defects, diseases of the eyes and diseases of the cardiovascular system (involving the heart and blood vessels).

"The registrants with diseases or conditions causing them to be classed I-B (qualified for limited military service) have been considered as men who might be suitable for service after correction. \* \* \*

"Of the 11,869 registrants classed I-B (qualified for limited military service), 9,443 (79.6 per cent) were found to have only one defect causing classification I-B, 2,122 (17.9 per cent) two defects causing classification I-B and 304 (2.6 per cent) three or more defects causing classification I-B.

"In all, 7,543 (63.6 per cent) of the 11,869 registrants classed I-B may have remediable defects and through correction and treatment may be prepared for general military duty.

"The nature of the 8,712 remediable defects of these 7,543 registrants was determined. Primary, secondary or latent syphilis was the most common, with 2,752 (31.6 per cent) of these defects in this group. Defective and deficient teeth were the defects for 1,796 registrants, hernia for 1,293 and gonorrhea for 921.

"In addition to the 25,184 registrants classed I-A (available for general military service), 7,543 registrants who were qualified for limited military service may have remediable defects. Thus in considering possible manpower for military service through correction and treatment, approximately two-thirds of the registrants in Tennessee may be made available for service."

In conclusion they say that "In view of the need for manpower for military duty the group of registrants rejected from general military service who have defects which are considered remediable represents a large force which can be restored for service for the country. This group of men with remediable defects represents American citizens on whom rests no less responsibility for military service than on their fellow citizens found to be physically acceptable.—*A. M. A. News*.

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## ARMY-NAVY "E" GIVEN RED CROSS BLOOD DONOR SERVICE

The Army-Navy "E" has been awarded to the American Red Cross Blood Donor Service in recognition of its achievement in collecting blood for the nation's armed forces. A total of 461,493 pints of blood have been provided by men and women of this country voluntarily as their contribution to the war. The quota re-

quested by the Army was exceeded by 81,493 pints in the blood contributions made through the Red Cross. More blood will constantly be needed and this will be collected in the Red Cross centers established for that purpose. These centers may be found in any of the large cities throughout the country.

## NEUROSES AND PSYCHOSES IN WARTIME\*

By CLARENCE M. TRIPPE, M.D., F.A.C.P., Asbury Park, N. J.  
Medical Officer, Veterans Administration

It is clear that this war will inevitably be a war against our civilians. The statement of Abraham Lincoln that the enemy could never reach this country in sufficient force to accomplish results no longer holds true. The enemy today is virtually at our very gates. Drone of motors has been heard off the West Coast. Scores of our ships are being sunk by submarines off eastern coastal waters, and obviously submarines will shell our eastern ports.

Coming of war to these shores will bring out neuroses and psychoses in civilians. This may seem remote now in view of what has been termed our complacency. It probably seemed remote in England before the German shells began to fall on London and other cities and villages.

In a poll of housewives conducted in New York City during March, 1942, 60 per cent admitted that their sole or greatest fear was from air raids.

It has been estimated that 90 to 95 per cent of all patients, regardless of diagnosis, present definitely predominating symptoms of psychoneurosis, either existing as a sole entity or superimposed upon organic disease.

Kardiner,<sup>1</sup> one of America's leading authorities on the neuroses and psychoses of war, writes, "No psychiatric symptom complex is observed in war which does not occur in peace. The only influence that war has is that it offers opportunities for the development of neuroses in much greater concentration and frequency than do the conditions of peace." In short, neuroses simply blossom out during wartime.

Hitler recognized this when he wrote in *Mein Kampf* "Mental confusion, contradiction of feelings, indecision, panic—these are our weapons. Our strategy is to destroy the enemy from within, to conquer him through himself."

This is a war of nerves. Says Seabury,<sup>2</sup> "It

was planned to upset our nerves, as fiendishly calculated as a horror story, as evilly schemed as a murder mystery. France fell June 22, 1940, the white residents of Singapore did not take the Japanese threat seriously; they jazz-danced to the last. That is the way Hitler wants us to behave. Indifference, then hysteria."

Chief and predisposing causes of neuroses and psychoses of war are a neuropathic or psychopathic inheritance and a previous nervous or mental breakdown, according to Hurst<sup>3</sup> in his recent textbook.

Some men are constitutionally brave, others are constitutionally timid; the average man is neither. There are a few people who do not know what fear is; their bravery is so natural to them that it is hardly a virtue. Every hardship is a joke. They do not endure hardship, they deride it. As for death, it is in a way to them the greatest joke of all.

Men and women naturally feel frightened when first exposed to war dangers. This applies to civilians in the same way as it applies to soldiers going to the front or encountering the first bombardment. When exposed both perspire freely, their hands shake, their hearts beat rapidly, and each time they hear the whistling of a shell they duck their heads.

The bravery of these is a genuine virtue as it consists in complete suppression of *natural* fear. As one soldier described his experience: "Your teeth may chatter, and your knees may quake, but as long as the 'real-you' disapproves and derides this absurdity of the flesh, the 'composite-you' can carry on."

Gregory Zilboorg<sup>4</sup> asks, "What made the Londoner survive? What made the Muscovite survive, and rise and hit back, and hard? Not his ability to sit tight for defense," he answers, "but hate, transformed into social wrath and rage. Dennis McEvoy, who saw the German

\* Read before the General Medical Session on War Medicine at the Annual Meeting of The Medical Society of New Jersey, April 21, 1942.

1. Kardiner, A.: "The Neuroses of War." War Med., 1:219, March 1941.

2. Seabury, David: "The War and Our Nerves." Bull. Town Meeting, 7:8-9, March 9, 1942.

3. Hurst, Sir Arthur F.: "Predisposing Causes of War Neuroses." Med. Diseases of the War, London, Edward Arnold & Co., Pub., pp. 1-4, 1941.

4. Zilboorg, Gregory: "The War and Our Nerves." Bull. Town Meeting, 7:12, March 9, 1942.



air raids over Moscow, tells us how people would stop in their tracks, raise their heads toward the death-bearing skies, and, with clenched fists, shout curses and threats to the bombers. There is more than the dramatic impetuosity of the Russian temperament in this; it is scorn and readiness to destroy the enemy, even with one's bare fists if necessary. This is what wins wars. Good healthy war morale is not merely courageous cheerfulness in the face of mortal danger, but the grim awareness that war, like pestilence, legitimately calls upon us not to be afraid to destroy and to kill this danger. We must kill a great deal of our goodness," says Zilboorg, "in order to fight a war. This is the first act of the psychological scorched-earth policy we must perform within ourselves, lest the attacker grab our goodness in order to kill us with it."

Rage, interpreted in terms of righteous indignation, begets courage. Courage will thus prove to be the prime factor that will determine character which in the mental field means temperament, and it means also upbringing, including education and discipline.

Experience at the Jordanburn Hospital in Edinburgh was that breakdowns have been uncommon and have occurred essentially in predisposed persons who have suffered from former emotional instability, neurotic symptoms, but were able to make a reasonable adaptation. This was in such cases the last of many difficulties and it immediately precipitated the illness. No breakdown was noted in a civilian who was of well-adapted personality before the war.

Stalker<sup>5</sup> writes, "All people, men and women (in England), are standing up to the strain of war conditions with fortitude, and although unfortunate and tragic cases occur, yet, on the whole, the position is accepted with equanimity."

Gillespie<sup>6</sup> agrees with all other eminent British psychiatrists as to the relative scarcity of neurotic and psychotic manifestations among civilians, as presumptuous as the statement seems.

Harris<sup>7</sup> recently released the statistics of a refugee reception center in a heavily bombed district. Out of 435 admissions there were only 23 precipitated nervous breakdowns, and these cleared up largely with one night's rest. He found no cases of conversion hysteria, organic confusion, nor confusional states even following exposure to blast or carbon monoxide poisoning.

This problem resolves itself into the recognition and care of civilians in every community naturally susceptible to psychological breakdown—men, women and children alike.

Their acute reactions are likely to be of the nature of mild panic, extreme and aimless restlessness, with all the appearance of terror, or, on the other hand, of immobility resembling stupor, but accompanied sometimes by intense preoccupation with the danger of falling bombs. Again these are likely to occur in the predisposed of the anxiety type.

Dr. Gillespie points out that in the more acute type of panic, movements are almost entirely undirected; in less acute states of panic fear, the patient is likely to enter a fugue—he will be found perhaps miles away from where he started, professing a loss of memory, which may be genuine to the extent that passing impressions have been so blurred during the fugue as to make recollection difficult. In the acute panic case actual mental confusion can account for nearly complete failure to comprehend the environment, and the resulting amnesia is genuine.<sup>8</sup>

According to Dillon,<sup>9</sup> 70 per cent of all cases will suffer from *anxiety neuroses* characterized by fearful states accompanied by shaking, jumpiness, dizziness and headache. The remaining 30 per cent will comprise confused or stuporous conditions, hysterical paralyses and mutism, fugue states with amnesia.

The first step in the handling of cases is to recognize the organic basis which may enter into the etiology in any given case. The first possibility is external concussion. Most practitioners have had experience in concussion,

7. Harris, Arthur: "Psychiatric Reactions of Civilians in Wartime." *Lancet*, 2:152-155, Aug. 9, 1941.

8. Gillespie, R. D.: "Psychoneuroses and Other Mental Conditions Arising Out of War." *Guy's Hosp. Gazette*, p. 40, Feb. 1941.

9. Dillon, F.: "Neuroses Among Combatant Troops in the Great War." *Brit. M. J.*, 2:63-66, 1939.

5. Stalker, Harry: "Panic States in Civilians." *Brit. M. J.*, 1:887, June 1, 1940.

6. Gillespie, R. D.: "Psychoneuroses and Other Mental Conditions Arising Out of War." *Guy's Hosp. Gazette*, p. 38, Feb. 1941.

and know, possibly from taking part in subsequent litigation, how hard it is to discriminate between actual neurological effects and superimposed neurotic reactions.

The actual neurological trouble can never be gauged by obvious external trauma. Even in patients with the most transitory phase of unconsciousness, a period of complete rest in a darkened room is essential. Everyone has seen the sequelae of inadequately treated concussion.<sup>10</sup>

But even more difficult is the problem of air concussion. In World War I this was called shell-shock, and it became an omnibus diagnosis under which were collected not only veritable and severe cases of air concussion but every form of hysteria, anxiety, psychosis and malingering. This air concussion was a new factor in pathology of warfare, owing to the introduction of high explosives on the field of battle. Since then the civilian populations have been exposed to even more powerful explosives and on a larger scale.

Shell-shock, neuro-circulatory asthenia, effort syndrome, soldier's heart, it is clear, are no suitable terms for the condition produced and should be eliminated. Air-concussion, however, is and will continue to be a definite factor in etiology.

Those who have accepted the theory that all functional disorders in wartime are psychogenic would do well to contemplate the effects of air concussion. That which happens is a hydrostatic effect, transmitted through the undefended abdominal wall, which so "concusses" the circulation as to produce three unusual features—severe headache, bloodshot eyes, and engorged gonads.

It is clear that, considered physiologically, this syndrome differs from that produced by direct concussion; but the two are often combined, as when a man is blown over by air concussion and hits his head on a hard object with sufficient force to produce unconsciousness.

The treatment, as in all departments of medicine, depends upon accurate diagnosis. It is obvious that this question is not purely a

medical one. Nor is it a military one. Future patients will doubtless, when attack comes to our shores, be persons who *should* have been treated before any attack or bombing.

In World War I psychopathic personalities, remitting psychotics, malingerers and psychosomatic cases were inducted into service. Ninety-seven thousand men during 1917 and 1918 were mustered out of the A. E. F. for psychoneurotic conditions only to be institutionalized in Veterans Administration Facilities at a cost to date of three billion dollars.

During 1941 medical board examiners of New Jersey and Delaware disqualified a total of 4,253 selectees for all reasons, after local boards had classed them as 1-A. Nine hundred and ten were rejected because of frank neuropsychiatric conditions.

From November 1, 1940, to January 1, 1942, 61,548 selectees were examined by New Jersey and Delaware army medical boards. Over 9,000 were excluded, of which 1,907 were psychiatric cases.

For every fifty men examined, one is an undesirable psychopath or mental defective.

This means that over 100,000 men during World War II will be handed back to their communities by Psychiatric Board examiners and, according to Pignataro<sup>11</sup> and others,<sup>12,13</sup> another 100,000 may be expected to be mustered out of Station Hospitals under Certificate of Disability for Discharge. Army Board psychiatrists cannot detect all the mentally unfit, as it is utterly impossible to diagnose such cases within the six or seven minutes allowed for each neuropsychiatric examination.

These rejectees should be supervised most closely as they will comprise the potential casualties in time of bombing, together with those frank mental cases recognized and placed in 4-F by local boards.

Then add to these the unstable, larger proportion of the population not within draft age and especially those members of the feminine sex as yet outside the domain of federal induc-

11. Pignataro, Frank P.: "The Psychoneuroses as They Pertain to Military Service." *Military Surgeon*, Vol. 90, No. 1:29-36, Jan. 1942.

12. Brun, R. (Swiss Military-Sanitary Station): "Classification and Treatment of Neurotics in Active Service." *Schweiz. Med. Wchnschr.*, 71:701-707, June 7, 1941.

13. Debenham, Gilbert; Sargant, William; Hill, Dennis, and Slater, Eliot: "Treatment of War Neuroses." *Lancet*, 1:107-109, Jan. 25, 1941.

10. Crichton-Miller, H.: "The Neuroses of Non-combatants in Time of War." *The Practitioner*, p. 618, July-Dec. 1939.

tion, and we have one out of every nineteen men, women and children in the United States at present, *before* air raids, unfit for any extra nerve strain.

It is plain therefore that a grave duty rests upon the shoulders of all physicians in treatment of neuropsychiatric diatheses.

The American Psychiatric Association divides psychoneuroses into seven types for the purpose of diagnosis, prognosis and treatment. They are hysteria, anxiety states, neurasthenia, hypochondriasis, reactive depression, psychasthenia and psychosomatic phenomena.

Pignataro<sup>14</sup> feels that the psychopathology underlying the various psychoneuroses is more or less similar and depends upon the operation of various subconscious mental mechanisms usually developing in childhood with constitutional predispositions as revealed by the family history, and environmental factors as revealed by one's personal history.

Hysteria and anxiety neuroses are responsive to suggestive therapy. Neurasthenia is difficult to treat and the prognosis is poor. Hypochondriasis is even more stubborn to treat and the prognosis is extremely poor, while reactive depressions respond well especially to amphetamine (benzedrine) sulfate and phenobarbital orally.<sup>15</sup> Psychasthenia, with its obsessions, compulsions and phobias, the rarest of the psychoneuroses, is rarely cured. The true psychosomatic states are puzzling because of the psychogenetic etiology affecting various body levels, and must be more carefully differentiated lest the conditions be organic.

The three chief psychosomatic disorders that bloom out under undue strain are: hyperthyroidism, cardiac manifestations, and peptic ulcers.

Thyrotoxicosis<sup>16</sup> shows no alteration of the basal metabolism rate. Cardio-circulatory cases have normal electrocardiograms.<sup>17</sup> Peptic ulcers recede when the tension of hard-driving persons with compulsive achievement can be persuaded to alter their mode of living. Other

psychosomatic conditions frequently encountered are: essential hypertension, functional gastro-intestinal disturbances with mucous colitis, bloating, dyspepsia and diarrhea. Less frequent are: bronchial asthma, certain skin disorders, and diabetes.

Lack of time precludes discussion of personality or character disorders, the dependent infantile or parasitic personalities, together with their isolated, moody, and lonely brothers—those candidates for traumatic neurosis characterized by stammering, tics, easy fainting, inability to stand the sight of blood; those with alcohol and drug addictions, and the large unfortunate number of overt sex variants including homoerotics, one of the greatest problems in army or civilian life where herding of population is requisite.

The chief psychopaths are manic-depressive, schizophrenic and paranoic. Curran<sup>18</sup> and others conclude that depressive states predominate over all other psychoses.<sup>19,20</sup>

Roughly speaking, there are two schools of thought on psychotherapeutic method—the “rapid” and the “analytical”. The former aims at removing symptoms, the latter at giving the patient insight. Three principles must be emphasized: 1, Different cases need different treatment; 2, the scope of treatment under war conditions is not the same as in peace; 3, few psychotherapists, if any, can effectively use more than one method they have found out to be the best.

In the voluminous literature reviewed extremely successful results have been obtained by the intravenous use of evipal,<sup>21</sup> sodium amytal,<sup>22</sup> pentathol sodium,<sup>23</sup> for rapid therapy in the acute case.

These can be administered to out-patients and they may leave unassisted within two or three hours.

Hypnosis, psychoanalysis, and long-drawn-out psychotherapy may be employed in those

18. Curran, Desmond, and Mallinson, W. P.: “Depressive States in War.” *Brit. M. J.*, 1:305, Mar. 1, 1941.

19. Boyer, George F.: “The Psychoneuroses of War.” *Canad. M. A. J.*, 45:53, July 1940.

20. Thom, Douglas A.: “War Neuroses.” *New England J. Med.*, 225:864, Nov. 27, 1941.

21. Stungo, Ellis: “Evipal Hypnosis in Psychiatric Out-Patients.” *Lancet*, 1:507-509, Apr. 19, 1941.

22. Sargent, William, and Slater, Eliot: “Acute War Neuroses.” *Lancet*, 239:1, July 6, 1940.

23. Searles, P. W.: “Intravenous Use of Pentathol for Anesthesia.” *J. A. M. A.*, 118:117, Jan. 10, 1942.

14. Pignataro, Frank P.: Same as 11, p. 31.

15. Hubert, W. H. deB. (France): “Acute Nervous Illness in Active Warfare.” *Lancet*, 240:306, Mar. 8, 1941.

16. Palmer, H. A. (York, England): “Psychobiologic Approach to the Acute Anxiety Attack.” *J. Ment. Sc.*, 87:208-229, Apr. 1941.

17. Crichton-Miller, H.: “Somatic Factors Conditioning Air Raid Reactions.” *Lancet*, 2:3-34, July 12, 1941.



cases who do not respond to the rapid treatment within three weeks.

In conclusion, it is well to reiterate the necessity of preventative measures to be constantly employed among all civilians. Menninger<sup>24</sup> points to the three great resources of play, work, and knowledge.

Recreation should not be merely a side issue. It should be constructively planned to suit each individual. Several vacations each year is suggested, more outdoor group playing when weather permits, and indoor games at all times.

Work should be of the type in which people feel they are doing something for the cause in their all-out effort directed toward future peace.

Knowledge is an antidote against poisoned morale and too much can never be attained, in order to aid one to maintain confidence in the body politic against the wide extent of subtle enemy propaganda.

The Association for the Advancement of Psychoanalysis best sums up the attitude America must recognize:

1. Under war conditions an increase in anxiety and tension is natural and inevitable. Unless this is realized, an individual might consider himself cowardly and contemptible when he is actually sharing a common experience. If anxiety incapacitates an individual, then it is most probably not associated with the war and represents a personal problem for which psychiatric aid might be consulted.

2. Planned and directed efforts are valuable psychologic assets in controlling anxiety. Foolhardiness and impulsiveness are no cures for fear. They actually undermine individual and group morale.

3. Inactivity and isolation from the group

beget anxiety. Useful, well-directed, interrelated tasks in the interests of the community not only diminish individual tensions but are constructive and sustain general morale.<sup>25</sup>

#### SUMMARY

1. Chief and predisposing causes are neuropathic or psychopathic inheritance and a previous nervous or mental breakdown.

2. Had the 1917-1918 Induction Board Examiners used present-day methods, three billion dollars alone would have been saved the United States for care and compensation for 97,000 preventable mental casualties.

3. Now, rejected neuropsychiatric selectees are returned to their communities to share with others, who are easily emotionally dislocated, benefits not afforded at the battle front.

4. British authorities have emphasized that there are few, if any, cases of neuroses and psychoses, except of transient nature, directly due to bombardment among men and women of average adjustment.

5. Those who are subject to personality changes in peace times will likewise be affected in wartime.

6. Seventy per cent of these will display simple fearful states accompanied by shaking, jumpiness, dizziness, and headache. Thirty per cent will become confused or stuporous and display paralysis and mutism, fugue states with amnesia.

7. Treatment will be amazingly successful under immediate attention by competent physicians assisted by their corps of intelligent nurses and trained nursing aides.

8. A program of recreation, occupation and education will not only tend to prevent such casualties but will rapidly rehabilitate the few that occur.

24. Menninger, Karl A.: "Civilian Morale in Time of War and Preparation for War." *Bull. Menninger Clinic*, 5:194, Sept. 1941.

25. *Ed. J. A. M. A.*, Vol. 118, No. 8, p. 624, Feb. 21, 1942.

## NOCTURNAL ANGINA

### A SYMPTOM OF CORONARY INSUFFICIENCY

By BENJAMIN RUBIN, M.D., South River, N. J.

It is the purpose of this communication to emphasize again that symptoms of coronary artery disease may manifest themselves only in the *recumbent* position and since our patient was in this position for any length of time only during the night, his symptoms were nocturnal. Electrocardiographic evidence of coronary insufficiency in one such case is presented.

Vaquez gave a special name to this type of angina and spoke of it as "the angina of rest"; although Thayer<sup>1</sup> thought that these patients had aortitis, syphilitic in origin and that these symptoms were similar to nocturnal dyspnea. Our patient neither had any evidence of syphilis nor was he dyspneic during the attacks. Furthermore, he had no evidence of left heart failure at any time.

M. W. was a 45-year-old male, quite active in his affairs, walking a good deal, and conducting business on a large scale. He was quite free of any symptoms until three years before he consulted me. He then began to complain of severe pre-cordial pain occurring about two to three hours after he went to bed, and radiating to his back and down the left arm to the fingers. Otherwise, he was quite well, having no cardiac symptoms whatsoever.

His attacks occurred with such regularity that since the onset the patient could no longer conduct his regular business because of lack of sleep. During an attack the patient discovered he could alleviate his pain by getting out of bed and walking around his room. He then would fear to go back to bed, lest the pain recur.

The attacks became more severe and frequent and the patient discovered that nitroglycerine tablets by mouth would curtail an attack but would not prevent it.

When I first saw the patient he was tired and looked worn out. His attacks were so severe and lack of sleep so tired him that he begged for any kind of relief.

Physical examination was quite negative except for a labile blood pressure ranging from 120/70 to 180/100, falling to the low figure after a few minutes of rest. He, however, had evidence of peripheral vascular disease. Pulsations at the dorsalis pedis and posterior tibial arteries were absent and oscillometer readings were absent at both ankles and below the knees. Incidentally and casually, the patient said he had calf pains after walking several city blocks. X-rays taken of both legs showed calcification in the tibial vessels. There were no murmurs heard over the precordium. Fluoroscopic examination revealed a moderately enlarged left ventricle but no abnormalities were noted in the arch of the aorta.

A blood Wassermann was negative.

An electrocardiogram, aside from some widening in the QRS complex of Lead I, was essentially the same as one done a year previously at another institution.

At no time did the patient have symptoms referable even remotely to his heart during the waking hours, even after a very busy day which consisted of running up and down stairs. It is true, his threshold for pain was diminished, but not so much that he did not feel his pain at night quite intensely.

The symptoms were so severe and although the patient would sleep unright in a chair, the pain would recur, responding, strangely enough, to nitro-glycerine.

In order that all other causes would be ruled out, x-rays of the thoracic spine and a gastrointestinal series were done to rule out vertebral disease or possibly a diaphragmatic hernia getting caught while pushed up past the diaphragm. These tests were all negative, and in preparation for a para-vertebral block, we tried to get more evidence to incriminate directly the coronary vessels as the origin of these somewhat bizarre symptoms.

An electrocardiogram (Figure A) was accordingly done while the patient was in the recumbent position; another was done after the

1. Thayer, W. S.: *International Clinics I*, Series 33:1, 1923.

patient had breathed deeply into a paper bag for one minute. During this minute he took eighteen very deep breaths, rebreathing the air in the paper bag which was held tightly over his nose and mouth. A third electrocardiogram was then done which is shown in Figure B. After ten minutes of deep breathing without a bag another tracing was no different from the one shown in Figure A.

Although no precordial pain was induced by the rebreathing, a typical electrocardiogram of myocardial anoxaemia was obtained; viz.: (1)

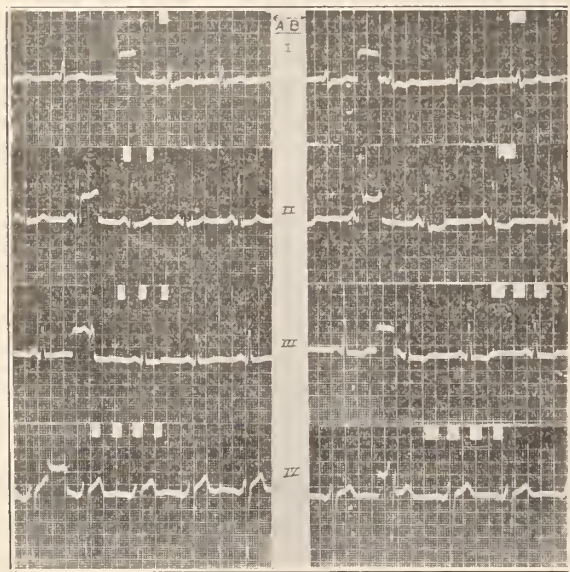


FIGURE A.

FIGURE B.

depression of the ST segments most marked in leads II and III; (2) inversion of the T waves in all three leads. The deviations from the control tracing met the criteria laid down by Levy et al.<sup>2</sup>

While we were considering a para-vertebral block the patient asked if he could take a holi-

day for a few days. It was during this holiday that the patient had his final attack. His wife told me that he was feeling particularly gay before he went to bed about 3:00 o'clock in the morning. About 6:00 o'clock he awakened with severe pre-cordial pain, had an ashen face with beads of perspiration standing out on his forehead. He asked to be helped to the bathroom and on his way he became lifeless.

#### DISCUSSION

The symptoms in this case may be explained by the assumption that this patient's diastolic pressure fell below the level that would adequately fill the coronary vessels since it is during diastole that the coronary vessels fill. We have no direct evidence for this, but the outcome of the case and the change in the electrocardiogram following anoxaemia of the myocardium are presumptive evidence that the patient had coronary insufficiency, the basis of which can only be speculated upon. The relief from nitro-glycerine could be explained by its effect of dilatation on the constricted coronary vessels, due to anoxaemia caused by the poor diastolic filling.

It should be noted that we obtained our electrocardiographic changes with a simple paper bag. This can be used in the office instead of the complicated apparatus used by Levy et al.<sup>2</sup>

#### CONCLUSIONS

A case of nocturnal angina has been presented showing electrocardiographic deviation of the ST segments following a rebreathing test which is indicative of coronary insufficiency. The fatal outcome of the case supports the evidence obtained.

The effect of nitro-glycerine in relieving but not preventing the attacks is discussed.

2. Levy, R. L.; Bruenn, H. M.; Russell, N. G.: The Use of Electrocardiographic Changes Caused by Induced Anoxaemia as a Test for Coronary Insufficiency. *Am. J. Med. Sci.*, 197:241, 1939.



## THE INDICATIONS FOR SPLENECTOMY IN GAUCHER SPLENOMEGALY

By ABRAHAM O. WILENSKY, M.D., New York

Repeated episodes of minimal or maximal hemorrhage in association with enlargement of the spleen are usually the result of a hemolytic abnormality occurring either as a pathological entity by itself, or as a symptomatic manifestation of another form of disease. In the first group, splenectomy is a curative measure (1) in the forms of hemolytic icterus in which spherocytes are present in the circulating blood, or (2) in cases of thrombocytopenic purpura. In the second group, splenectomy is a valuable measure, (3) for those cases in which excessive enlargement of the spleen becomes a physical handicap and leads to cachectic states and (4) for those cases in which repeated or massive hemorrhage occurs because of accompanying thrombocytopenic manifestations.

Both of the last two conditions are encountered in Gaucher's splenomegaly and give adequate and imperative indication for splenectomy as a palliative therapeutic measure. In any case splenectomy is best done if possible during a so-called remission period.

The following two cases illustrate this second group exceptionally well.

### CASE 1

Pt.: B. G. Flower and Fifth Avenue Hospital, No. 1942/3046.

In February, 1916, when the patient was 13 years of age, pain developed in her left knee and the knee became swollen. The condition was treated as "rheumatism". She was well after that for two and one-half years, during which time no limp was noticeable. Pain returned at the end of that time and she began to limp. The leg was then immobilized. It was thought that there was a floating body in the knee joint. An abscess formed thereafter in the back of the knee. At the Kings County Hospital the abscess was opened and reopened, and, finally, the bone was curetted seven weeks after the second operation. The diagnosis now was osteomyelitis. Sinuses were still open and draining pus mixed with blood at the time of discharge from the hospital.

She was at the Hospital for Joint Diseases in 1917, where a sequestrum was chiseled out from the lower end of the femur. No histological examination was, however, made of any bone tissue. A diplococcus was found in the pus from the wound; and, later, the wound became contaminated with bacillus pyocyaneus. Finally the patient was discharged in good condition.

The patient was readmitted in 1921 because of the presence of a sinus tract leading to rough, soft bone in the lower part of the left femur near the popliteal fossa. The muscles were atrophied but there was free movement in the hip and knee joint. A continuous discharge of yellowish-green pus escaped from the sinus. Again she was operated upon; a sequestrum was removed; and she was discharged from the hospital in good condition four months later.

In 1931 the patient was married. In 1932 she was admitted to the Crown Heights Hospital for the delivery of a child. The baby was delivered with forceps but died four days later, presumably of an intracranial hemorrhage. The patient herself had an excessive amount of postpartum bleeding. A large spleen was discovered at this time. A marked anemia resulted and several transfusions were given. Seven x-ray exposures over the spleen were also given but there was no change in the size of the spleen thereafter. The patient was discharged from the hospital two weeks after delivery in generally good condition. The question of splenectomy was discussed at this time.

The patient was then immediately admitted to the Bronx Hospital where she was studied by the medical department. The following additional history was elicited: On the father's side there is a rather large history of cancer, but no history of any bleeding tendency. On the mother's side there is a history of a tendency to bleed frequently. Two brothers also have splenomegaly, proven, by sternal puncture, to be Gaucher's disease; and one of them died of a streptococcic infection of the throat

at the age of 39 years. The patient's mother herself was said to bleed excessively at each childbirth.

At this time the physical examination of the patient showed a young, slightly built woman, with fair nutrition. The tongue showed some atrophy of the papilli. The fundi showed slightly engorged veins but the lymphatics were not enlarged. The heart was hypoplastic and there was a systolic murmur over the pulmonic area which was taken to be hemic in origin. The liver was slightly enlarged. The enlarged spleen extended all the way down to the umbilicus, and was hard and fibrotic. The limbs were negative with the exception of the scar of the previous operation. There was no enlargement of the superficial lymphatic glands.

X-ray examination of both femora showed marked irregular broadening of the lower two-thirds of the femur with marked irregularities in structure. The radiologist reported the lesion as "chronic osteomyelitis".

The complete hematological and chemical work-up is shown in the accompanying table (table 1).

The patient was carefully observed in the hospital and was given several transfusions. No definite conclusion was reached as to the performance of a splenectomy and the patient was discharged from the hospital in reasonably good condition.

In 1935 she was admitted to the New York Hospital for the delivery of her second child. There was a post partum hemorrhage of 1000 c.c., but, nevertheless, both mother and child did well. At the present time the child is seven years old and is in perfect health and there are no evidences of any splenic enlargement or hematological disease.

Between 1935 and 1941 the patient was observed by various men including Dr. Rosenthal, who definitely made the diagnosis of Gaucher's splenomegaly. There were frequent small hemorrhages from the mouth, nose, etc., but there was no great loss of blood. In April, 1941, splenectomy was advised, because the spleen had enlarged greatly in size by this time and it was feared that if the enlargement continued and became too excessive it would bring

about a cachectic state. The blood picture remained unchanged. (See table 1.)

In May, 1941, I removed the spleen and a mass of accessory spleen tissue. There were no difficulties either during the operation or during the convalescence. The operation was followed by a transfusion. Following the operation, the number of platelets rose to normal and the red blood cell count and hemoglobin content improved markedly. The patient left the hospital twelve days after the operation in very good condition.

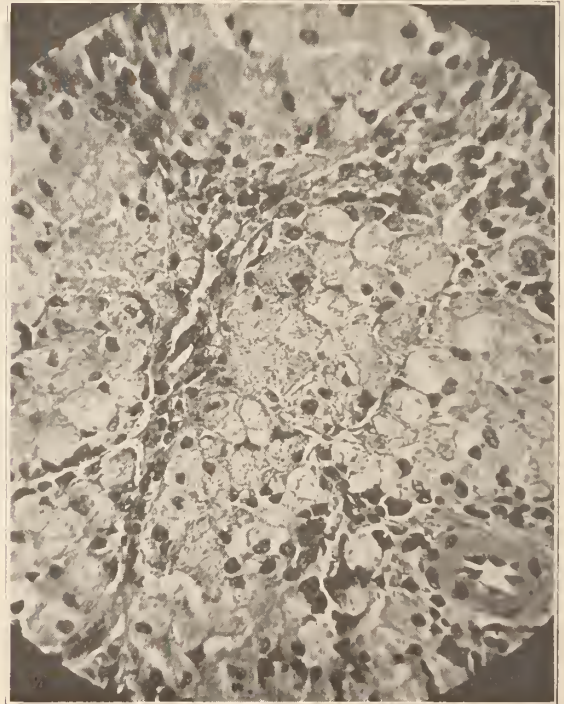


FIGURE 1  
High-power photomicrograph of the spleen in  
Case 1.

The examination of the spleen, made by Dr. Youland, is as follows:

"The spleen is greatly increased in size and measures 25 x 15 x 8 cms. in thickness. The weight is 1482 gms. The external surface presents a smooth, glistening, moderately thick opaque capsule. The splenic tissue shows characteristic mottled areas appearing greyish and varying in size and shape, and separated from one another by thin, darkish, linear tissue. The splenic pulp appears as an essentially uniform, finely mottled, pinkish-grey tissue, the mottled

DATE	PLATELETS	% HEMOGLOBIN	RED BLOOD CELLS	WHITE BLOOD CELLS	POLYMORPHONUCLEARS SEGMENTED	LYMPHOCYTES	LYMPHOBLASTS	MONOCYTES	MYELOCYTES	EOSINOPHILES	BLEEDING TIME IN MINUTES	COAGULATION TIME IN MINUTES	TRANSFUSIONS (Citrates) c.c.	MISCELLANEOUS
11-23-32		48	2,300,000	7,200	65	25		10						Done several hours post-partum. One normoblast oxidase stain; negative
11-24-32											10		500 c.c.	
11-25-32		45	2,100,000	2,500										
11-26-32														
12-9-32		45	2,300,000	3,200	75	23								November 26-December 12, 7 x-ray exposures.
12-27-32		51	2,200,000	3,900	73	14	2	2						
12-28-32	80,000										1	7		<i>Blood Chemistry</i> Calcium—10.0; phosphorus—3.7.
12-29-32	96,000	38	2,560,000		70	24	3	1						
12-30-32		40	2,480,000	2,800	68	7	6	5	10					<i>Blood Chemistry</i> Glucose—102.0; uric acid—3.4; urea N.—11.7; N.F.N.—29.3; creatinine—1.18.
1-2-33		53	3,290,000	2,650	69	19	2							
1-5-33		50	3,180,000	3,900	39	29		1	1	1				
1-9-33	80,000	50	3,040,000	2,000	68	18		10						
1-10-33														Van den Bergh—Direct—negative. Indirect—less than ½ unit for 100 c.c. Icteric Index—5.0
1-12-33	104,000	49	3,280,000	1,900	72	12		7		3	4	8		
10-2-35	65,000	71	3,850,000	3,100	51	44		5						Macrophages—0%
11-21-35	140,000	58	3,790,000	3,600	74	22		5						Macrophages—1
4-23-41	45,000	64	3,930,000	3,400	53	44		2	1					
5-3-41	SPLENECTOMY													
5-8-41	260,000	68	3,770,000	8,400	77	12		11						Basophiles—1
5-24-41	440,000	69	4,110,000	7,900	76	17		6						Reticulocytes—less than 0.5%
9-6-41	200,000	60	3,510,000	7,200	47	48		4	1					
10-8-41	220,000	70	4,520,000	8,800	40	51		7	2					

TABLE 1



areas alternating with thin, dark-red, intervening tissue. Deeply imbedded in the splenic pulp is an irregular, nodular hemorrhagic mass measuring 1.5 cm. in diameter, and another small yellowish nodule.

"Microscopically, various sections show large alveolar spaces filled with closely packed, large, pale cells. These cells show only a trace of staining with eosin and are prominent because of their large nuclei. The outline of these cells can not be made out, for the most part. Scattered, minute, collections of red blood cells can be made out in many of these alveolar areas. The outline of the alveolar areas likewise tends to be indistinct but, here and there, strands of hypertrophic fusiform cells suggest the original sinusoidal wall. Some of the alveolar structures show extensive, and peculiar, reddish pigmentation, the pigment substance being collected in masses. Some of these pigment masses are intimately associated with clumps of red cells inside of the spaces. In some of the spaces the red cell clumps have pushed the large endothelial cells toward the periphery of the sinusoid. The entire spleen, in the sections examined, is made up of these large alveolar or sinusoidal spaces filled with hypertrophic, roughly spheroidal and pale staining cells. Hemorrhage into these sinusoidal structures is fairly extensive throughout the spleen. Scattered throughout the splenic tissue as described above are collections of small lymphocyte follicles. Many of these follicles show thickened, central arterioles. No germinative activity is seen. Microscopic section of the small, yellowish firm nodule shows a characteristic, post-thrombotic mass consisting of dense, fibrillar substance with blackening of some of the fibrils. In microscopic sections of tissue fixed in absolute alcohol, the hemorrhages into the alveolar masses are found to be extreme. There is very little, if any, pigment present in these hemorrhagic areas. The endothelial cells vary in appearance from that of a solid granular structure to marked, and almost complete, vacuolization."

Diagnosis: Gaucher splenomegaly.

The patient has been followed regularly. There have been no hemorrhages of any kind since operation. The general health has improved very much and the patient looks well.

## CASE 2

Bronx Hospital No. 104670.

A young man of Italian parentage, whose grandfather is said to have had similar bleeding episodes, came to the hospital with the history that from the age of six years he had been subject to: (1) frequent epistaxis lasting several hours, especially in winter; (2) alarming episodes of bleeding lasting from two to three days following any tooth extraction; (3) very excessive ecchymosis following even slight trauma; (4) over-prominent abdomen as a child causing his friends to call him "sparrow belly".

Because of these symptoms he was studied at another hospital about six months previously where a diagnosis of purpura hemorrhagica was made. Radiologic studies made at that time showed no changes in the long bones or in the skull. Except for this bleeding tendency the patient has had no symptoms of any kind referable to any part of the body, and he has continued to look relatively well up to the present time.

Several months ago following trauma to the thigh an especially large subcutaneous hemorrhage developed and because of this and because of continuing nose bleeds and because he himself felt a mass in the abdomen he came to the hospital for treatment.

The patient was a tall, thin, pale, light olive complexioned man whose general physical examination was essentially negative. There was no enlargement of the lymph glands anywhere in the body. No petechiae or ecchymosis were visible and there was no evidence of bleeding about the gums. In both of the eyes there was a slight heaping-up of the conjunctiva, suggestive of a pinguicular formation. There was a soft systolic murmur at the apex.

The entire left half of the abdomen was occupied by a large, non-tender mass which was evidently a greatly enlarged spleen. The liver was palpable about one-half inch below the costal margin. There was no ascites.

The complete hematological work-up is shown in the accompanying table (table 2).

Under the diagnosis of thrombocytopenic purpura I explored the patient and noted the following: No excess bleeding on entering the abdomen; no ascites; the spleen occupied the

Date	PLATELETS	% HEMOGLOBIN	RED BLOOD CELLS	WHITE BLOOD CELLS	POLYMORPHONUCLEARS	EOSINOPHILES	BASOPHILES	BAND FORMS	LYMPHOCYTES	MONOCYTES	BLEEDING TIME IN MINUTES	COAGULATION TIME IN MINUTES	PROTHROMBIN IN MINUTES	TRANSFUSIONS (citra) c.c.	MISCELLANEOUS
10-7-39	35,000	69	3,720,000	2,500	61		1	3	28	7	2½	4½	Normal	250 c.c.	Blood chemistry: Normal Kahn and Wassermann tests negative; negative Bromosulphthalein test; "no dye present in 1½ hours".
10-9-39															
10-10-39														250 c.c.	
	Operation: 9:25 a. m.-10 a. m. (Procaine "Spinal", 150 mg.).														
Splenic Artery	33,000	76	4,300,000	4,100	80		1		14	5		3	Normal		
Splenic Vein	46,000	72	3,960,000	4,600	72			22		6		2	Normal		
11:00 a. m.	56,000			9,100	69			18	10	3					
2:00 p. m.	56,000			138,000	63			26	2	3					
4:00 p. m.														400 c.c.	
4:45 p. m.	50,000			13,200	62	1		26	4	7					
9:00 p. m.				11,200	78			10	12						
10-11-39		50	2,940,000	10,700	71			3	12	14					Poikilocytosis
10-12-39	220,000														
10-13-39	250,000														
10-14-39	420,000														
10-17-39	660,000	56	3,200,000	13,700	66	10		1	10	13					
10-20-39	540,000														
10-23-39	570,000														

Discharged.

TABLE 2.

entire left half of the belly and a small accessory spleen about one-half inch in diameter was present near the tail of the pancreas. Except for some enlargement, the liver looked normal. No enlargement of the abdominal lymph nodes was present. The spleen and accessory spleen were removed and a biopsy was taken from the liver. Specimens of blood were also taken from the splenic artery and splenic vein.

The histological examination of the removed spleen was made by Dr. Felsen, and is as follows: "The spleen is 26 x 15 cm. in size and weighs 1750 gm. The surface contains two nodular projections and also an irregular area of infarction which is greenish-grayish-yellow and over which the capsule is firmly adherent. Beneath the surface are numerous firm, nodular masses which are well encapsulated and easily shelled out. Some are the same color as the spleen, i. e., brownish-red, and others contain yellowish areas. The spleen proper is reddish-brown, fairly firm and fleshy.

"Sections of the spleen exhibit small groups of large polyhedral cells with clear neutrophilic cytoplasm and small, rather pyknotic nuclei. These cells have almost entirely replaced the splenic lymph nodules and occupy both the sinuses and pulp. In one section there is a large area of hemorrhagic infarction and many lymphocytes are present. A more pronounced picture is seen in the accessory spleen. The liver shows similar changes and many large cells laden with brown pigment are noted. The liver cords are atrophic or show other less pronounced degrees of degeneration. Diagnosis: Gaucher's disease."

The patient made a very uneventful convalescence and was discharged from the hospital approximately two weeks after being operated upon.

#### COMMENT

This peculiar disease is one of the forms of general lipidosis and is produced by the accumulation of kerasin in the reticular cells and histiocytes of the lymph-hemopoetic organs. The typical Gaucher cell is large, swollen, pale, grayish white and translucent and occurs in strip-like accumulations in such extraordinary amounts as to give rise to marked enlargement of the spleen, liver and deep lymphatics and

to defects in the marrow of the long bones. Kerasin is that form of cerebroside found in this type of disease (reticular-cerebrosidosis) in contradistinction to other cerebrosides found only in the brain.

Even though about 150 cases of Gaucher's disease have been reported, the disease is still comparatively uncommon. The disease is widely distributed throughout the world, in all kinds of people, colored and white, but it seems to have a greater frequency among Jews. Females are affected more often than males. There is a strong tendency for a familial grouping among brothers and sisters. The disease commonly begins or is first recognized in childhood and adolescence. There is a group of comparatively acute fatal cases in infancy; but the usual chronic form develops somewhat later and may last for as long as 30 or more years.

In the usual chronic case there is a rather indefinite symptomatology characterized by various pains and aches, weakness and inability to carry on the customary daily occupation. Commonly the patient consults his physician first because of progressive enlargement of the abdomen. At other times, the chief complaint is the large or recurrent bleeding and the proneness to bleed. Another group comes with dragging pains in the thighs (femur) or back (spine) and this is commonly, as in our case, mistaken at first for an osteomyelitis or an arthritis, or a rheumatism or rheumatoid arthritis; and, as bouts of fever are common, the similarity is marked.

A complete physical examination is necessary if the diagnosis is to be made. An enlarged spleen is always present and easily palpable. This should act as the important clue. One should look for the following: (1) enlargement of the spleen, (2) enlargement of the liver and of the deep lymph nodes, (3) skeletal defects, (4) pigmentation of the skin, (5) cuneiform yellowish or brownish thickenings of the conjunctivae near the cornea, (6) hemorrhagic tendencies due to thrombocytopenia, (7) leukopenia, (8) microcytic anemia, and (9) general emaciation in advanced stages of the disease.

The most important of these are the enlargement of the spleen, the changes in the conjunc-



tivae and the bone changes which are most often first detected in the lower ends of the femur. The latter can often be demonstrated by the x-rays. Laboratory examinations usually show the presence of the anemia. Blood chemical studies give little help and the fats, phospholipids and cholesterol are ordinarily even somewhat below the normal. No increase in the amount of kersin in the blood is found.

In the cases with hemorrhage there is a more or less marked microcytic anemia; but, here, the important determination is the status of the blood platelets inasmuch as a marked diminution of them makes the imperative indication for splenectomy. No spherocytes are seen.

The diagnosis is easily made, or, when suspected, corroborated by the examination of the bone marrow obtained by sternal puncture.

Gaucher's disease is considered now as a constitutional disorder based mainly upon an abnormality in the chemistry of the lipid metabolism of the cells of the reticulo-endothelial system. A good deal of experimental work has been done, much discussion has taken place, and several assumptions have been made as to the chemical and other mechanism of this disease. In one of these (Pick) it is thought that there is general disturbance in the entire lipid metabolism; in the other (Schlagenhauser) it is thought that the metabolic dysfunction is localized in the reticular cells of the lymph-hemopoetic organs. In either case, the mechanism results in a most extraordinary storage within the latter cells of kersin and is analogous to that in the other lipid diseases.

In Gaucher's splenomegaly radiotherapy has proved to be a total failure as a therapeutic measure either for cure or for palliation. Practically no shrinkage in the size of the spleen is produced, no effect is discernible upon the blood status, and there is no beneficial effect as far as the general health is concerned. Should one, nevertheless, attempt its use, one should measure the dosage carefully against the production of any marked leukopenia.

For the internist and general practitioner, however, it must suffice at the present writing to understand that one can do little for this

disease either to halt its progress or to assure a cure. Therapeutic efforts can be directed only to the control of the mechanical disabilities produced by the enormous weight of the spleen, or of any complicating large or continued small hemorrhage. Splenectomy is then indicated, in either case as a palliative measure, but even so the indication is imperative. It is extremely important to remove any accessory splenic tissue at the time of the operation as otherwise the good effect of the splenectomy becomes invalidated. Transfusions of blood are a most useful adjuvant measure either before or after operation in order to counteract by replacement any undue depletion of the blood elements, before operation as an important preparatory measure, and directly after operation to overcome any undue amount of operative shock or to replace the blood lost in the spleen. When the patient is well prepared and the operation is skillfully done the removal of the spleen is well borne and no deleterious changes follow. The subsequent health of the patient is very much bettered.

The first case reported herewith illustrates exceptionally well the course of events in a typical long-standing chronic case including the bone manifestations and the mistaken diagnosis of osteomyelitis at the beginning, and the later repeated hemorrhages. The second case shows the effect of the diminution in platelets in causing the hemorrhagic manifestations. In either case the indications for splenectomy were absolute, and the later history shows how justifiable the operation was.

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## A NEW USE FOR WANGENSTEEN SUCTION DRAINAGE\*

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Many methods have been developed in the past to facilitate the procedure of thoracentesis. Among these are the Potain Aspirator, the vacuum flask and similar devices. Since the aforementioned methods are not completely satisfactory, most men still resort to the one or two syringe methods for aspiration. This procedure, too, has many disadvantages, viz.:

1. It is time-consuming and requires the constant attendance of a physician.
2. The piston and chamber often stick together because of the character of the fluid.
3. The needle frequently becomes displaced and requires reinsertion.
4. The possibility of the patient developing a pneumothorax is greater with the syringe method.

At the Newark Beth Israel Hospital, all of these methods have been tried, and found not entirely satisfactory. One of us (C. R. W.) decided to utilize the Wangensteen Suction Apparatus for thoracentesis.

### PROCEDURE

The Wangensteen Apparatus is set up in the usual manner. One may use the regular two-bottle method, or preferably insert a trap-bottle into the system. If the two-bottle method is used, it is necessary to place a calculated amount of fluid (water) in both the upper and lower bottles. This is not essential if the trap-bottle is employed. The rubber tubing from the upper bottle, or from the trap-bottle, as the case may be, and the glass adapter attached

to its distal end, are sterile (Fig. 1). The thoracentesis needle is pushed through a sterile rubber cork, then inserted into the pleural cavity, and the glass adapter is placed into the needle. The rubber cork is fixed to the chest wall with adhesive tape. The rate of drainage is controlled by either adjusting the stopcock and, or, by regulating the height of the upper bottle.

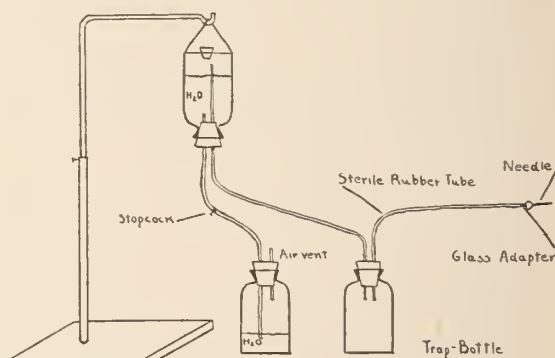


FIGURE 1.

This method has, we believe, the following advantages over the other methods:

1. It does not require the constant attendance of a physician.
2. The rate of aspiration is constant and can be easily regulated.
3. The possibility of the patient developing an uncontrolled pneumothorax is less than with other methods.

The above procedure has also been successfully employed for abdominal paracentesis with a slight modification at the distal end of the sterile rubber tube.

\* From Medical Service B, Newark Beth Israel Hospital, Newark, N. J.

# MATERNAL MORTALITY STATISTICS IN NEW JERSEY FOR 1941

## MATERNAL WELFARE ARTICLE NUMBER SEVENTY-FOUR

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey, and  
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,  
State Department of Health.

The maternal mortality rate in New Jersey for 1941 was 26 per 10,000 live births. All rates shown in the graphs are per 10,000 live births. Additional graphs were made this year in order to bring out wherein lie some of the weaknesses. We were able to do this because we received more detailed information from the histories and hospital reports.

than the urban, due largely to the deaths from toxemia. The United States rate is shown for comparison with the State rate.

Figure 2. This graph shows the prevalence in *percentages* of the various causes of maternal deaths. Toxemia not only has the highest percentage but it helps to increase the deaths from puerperal sepsis, puerperal hemorrhage, and other accidents of childbirth. A marked increase in the number of cases of toxemia was reported by the hospitals in 1941.

### MATERNAL MORTALITY RATES

#### NEW JERSEY

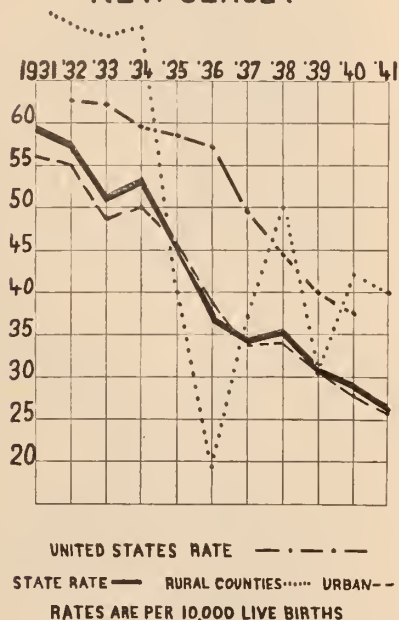


FIGURE 1

Figure 1 shows the marked decrease and trend in the mortality rate in the State since 1931 when the Maternal Welfare Committee's work started. On the average, about seven times as many births occur in the urban counties as in the rural counties, the urban maternal mortality, thus dominantly influencing the State rate. The rural rate varies considerably due to smaller figures but is, as a rule, higher

### MATERNAL MORTALITY

#### 1941 NEW JERSEY

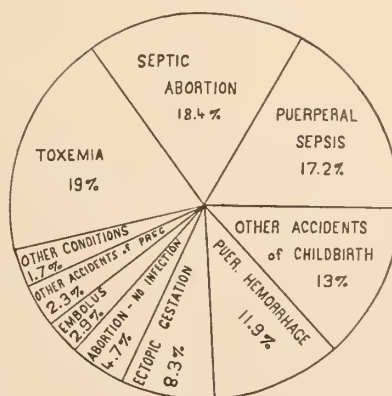


FIGURE 2

Figure 3. This is a map of New Jersey showing the maternal mortality rates in the various counties. Eleven counties had rates equal to or lower than the State rate, their average rate being 23 per 10,000 live births. Ten counties with an average rate of 37 had rates higher than the State rate. The maternal mortality rate for the *urban* counties was 25 while the rate for the *rural* counties was 40.

### PUERPERAL SEPTICEMIA

Figure 4. This map shows that 10 counties had rates lower than the State rate for puer-



# MATERNAL MORTALITY RATES BY COUNTIES

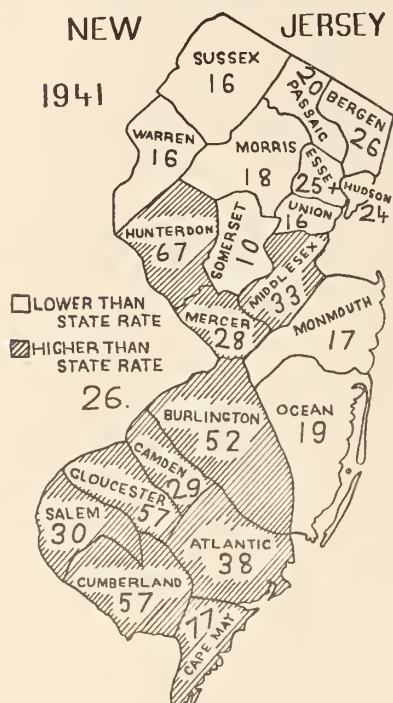


FIGURE 3

peral sepsis; seven of the counties had no deaths from this cause in 1941. Five were rural counties. The "white" counties had an average mortality rate of 2.4. These counties had 63 per cent of the births in the State. The "shaded" counties had an average rate of 8.5.

Figure 5. This graph shows the deaths from puerperal sepsis in relation to type of delivery. Over 60 per cent of these deaths followed Cesarean section although there were only 1,526 of these operations done. For further data on maternal mortality in Cesarean sections read the description of Figure 17. Seventeen and eight-tenths per cent of puerperal sepsis deaths followed *normal* deliveries although there were many thousands of these deliveries. These data show the need of more careful prenatal care to get the patient in better condition and the necessity of making an early decision as to the necessity for Cesarean section. Some of these patients were too anemic at the time of operation, and others were

in labor too long before the decision to operate was made. Some were *elective* cesareans, which fact shows the need for better technique.

## PUERPERAL SEPTICEMIA

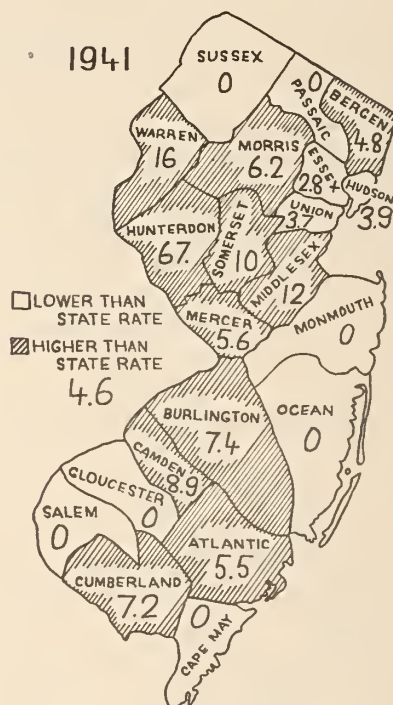
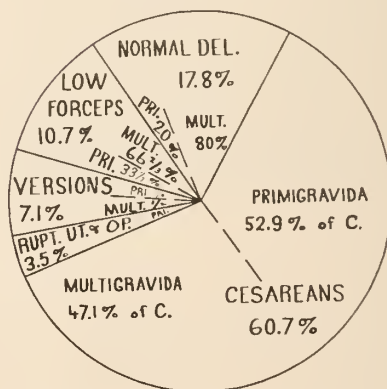


FIGURE 4

## PUERPERAL SEPSIS RELATION TO DELIVERY



GESTATION - 7 MOS. - 4 %  
" - 9 MOS. - 96 %  
LABOR - FROM 0 TO 4 DAYS  
2 HISTORIES INCOMPLETE

FIGURE 5

Figure 6. This graph shows the *trend* in the rates for puerperal septicemia deaths for the past eight years. The rural rate is considerably higher than the State rate in spite of the fact that five out of the ten rural counties had no death from sepsis. The rural rates for puerperal sepsis in 1941 was 7.8; the urban rate, 4.2; and the State rate, 4.6; slight increases over 1940.

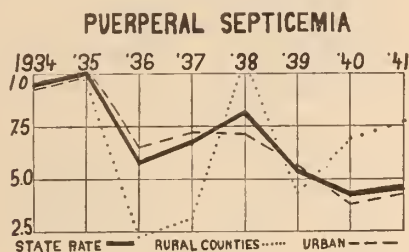


FIGURE 6

## SEPTIC ABORTION

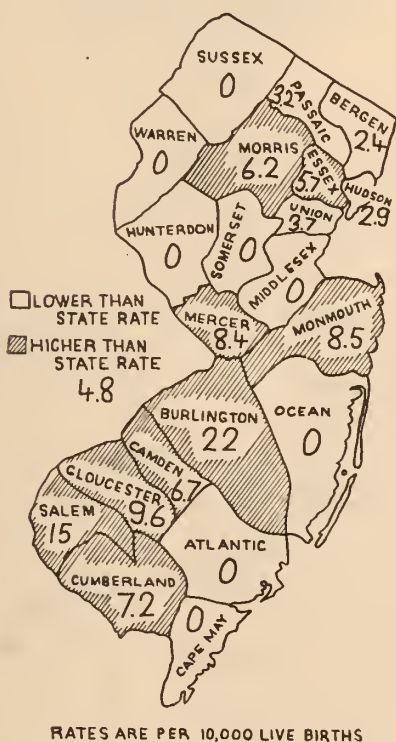


FIGURE 7

## SEPTIC ABORTION

Figure 7. Twelve counties had mortality rates which were below the State rate, and eight of these counties had no death in this classification. The average rate for the "white"

counties is 2.3 while the average rate for the "shaded" counties is 7.5 per 10,000 live births. The latter counties provided 53 per cent of the live births in the State. The average rate for septic abortion cases in the whole State is 4.8.

Education of the public as to the dangers of abortion should lower the death rate in this classification. Physicians should give more serious consideration to the treatment of abortion. All septic abortions are *not* criminal abortions.

Figure 8. The trend of the mortality rate due to septic abortion has gradually improved. In 1935 the rate was 8.5 while in 1941 it was 4.8. The rural counties had a marked increase in the death rate from this cause in 1940 and showed a slight improvement in 1941.

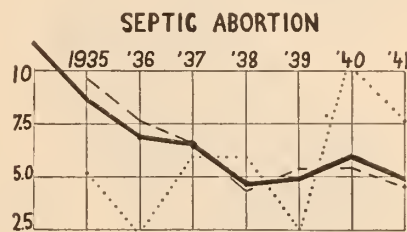


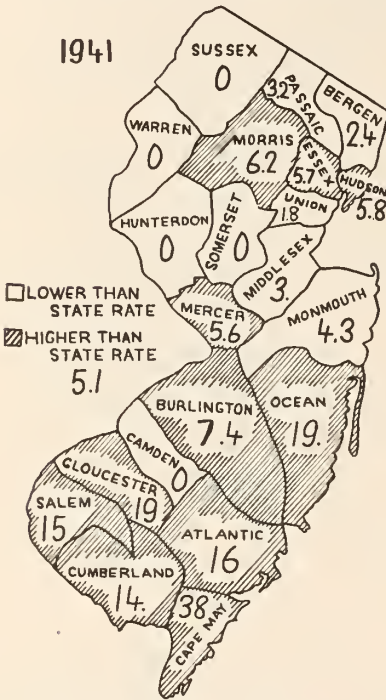
FIGURE 8

## TOXEMIAS OF PREGNANCY

Figure 9. This classification includes all types of toxemia, eclampsia, albuminuria, nephritis, hypertension, acute yellow atrophy of liver, etc. The State rate for 1941 is higher than it was in 1940. The hospitals reported a marked increase for 1941 in the number of toxic maternal cases. This increase indicates the need for better prenatal care. Slight toxic symptoms should be treated before they become marked. More preventive prenatal care should be provided. Diastolic blood pressure should be carefully watched since a rise in diastolic pressure is often an early sign of beginning toxemia. The fact that certain counties in the last year were without a death from toxemia suggests that each county must check its system of prenatal care as this offers a way to reduce deaths from toxemia. Reducing the prevalence of toxemia will also aid in reducing the maternal mortality rate in septicemia, hemorrhage, and other accidents of childbirth. At least two-thirds of

the toxemia cases are avoidable. The average maternal mortality rate from toxemia in the "white" counties was 3 per 10,000 while the average rate for the "shaded" counties was 8.9 per 10,000 live births.

TOXEMIA OF PREGNANCY



RATES ARE PER 10,000 LIVE BIRTHS  
FIGURE 9

Figure 10. This graph shows the deaths from toxemia in relation to *delivery*. Eighty-five per cent of these cases occurred in the third trimester of pregnancy and the majority of cases were full-term pregnancies. Twenty per cent of these toxemic cases died undelivered, 80 per cent were delivered. Only 50 per cent of these cases in the third trimester had live births. In studying these histories it is found that in many of these cases interference had been delayed too long. Many patients showing toxic symptoms with albumin present are treated and show improvement, and then instead of terminating pregnancy while in improved condition, the patient is allowed to go on until suddenly she becomes worse and dies. This relapse is almost sure to come and is always worse than the original attack. The effort to carry these cases beyond

eight months in the interest of the child is an error, as the risk to the mother is very great and the infant mortality in such cases is 50 per cent.

DEATHS FROM TOXEMIA  
RELATION TO DELIVERY

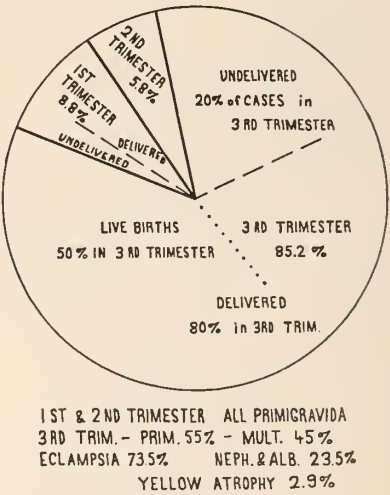


FIGURE 10

Figure 11. This graph shows trends in toxemias of pregnancy and indicates that on the whole the State rate from this cause of maternal mortality has gradually improved, except for a recent rise in the trend due to a 30 per cent increase in the maternal deaths in the urban counties in 1941. The mortality rate for the rural counties remains considerably above the State rate.

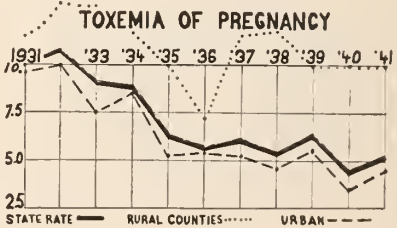


FIGURE 11

PUERPERAL HEMORRHAGE

Figure 12. Nine counties had no death from puerperal hemorrhage in 1941 and there were 13,826 live births in these same counties. Five counties besides these were below the State rate (two-thirds of the total number of counties in the State). The average mortality rate



for the "white" counties was 2.0 and that of the "shaded" counties was 6.7 per 10,000 live births.

### PUERPERAL HEMORRHAGE



RATES ARE PER 10,000 LIVE BIRTHS

FIGURE 12

Figure 13. This graph shows the type of hemorrhages included in this classification. Premature separation of placenta accounted for 20 per cent of these deaths and all these cases were toxic. Placenta previa caused 20 per cent of the deaths, leaving 60 per cent due to post partum hemorrhage. The post partum hemorrhage deaths were all in nine months pregnancies. The post partum hemorrhage was due to various causes, viz:

1. Following prolonged labor.
2. Following very short labor—possibly ruptured cervix (not stated).
3. Following elective Cesarean section for disproportion.
4. Retained placenta.
5. Following prolonged analgesia.
6. Following difficult delivery.
7. Following normal labor and delivery.

Fifty-eight per cent of these cases were mul-

tigravida and the majority of these hemorrhages followed normal labors and deliveries. Too much analgesia is a factor in causing some of these hemorrhages.

### PUERPERAL HEMORRHAGE

1941

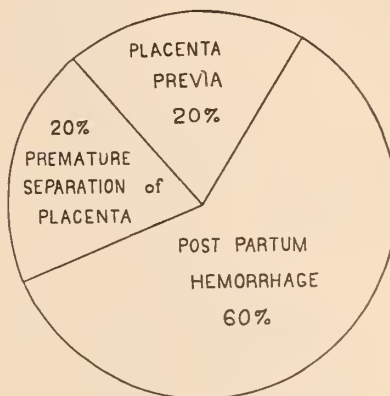


FIGURE 13

Figure 14. There was no improvement in the State rate for this classification in 1941 as the slight improvement in the urban rate offset the increase in the rural rate. The mortality rate, 2.6, for the urban counties follows closely the State rate as it is the largest group. The rural county mortality rate, 6.5, shows considerable variation from year to year and in 1941 was markedly above the State rate.

### PUERPERAL HEMORRHAGE

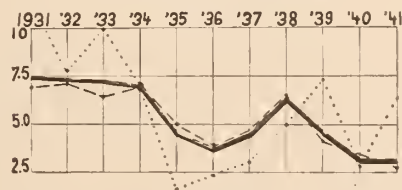


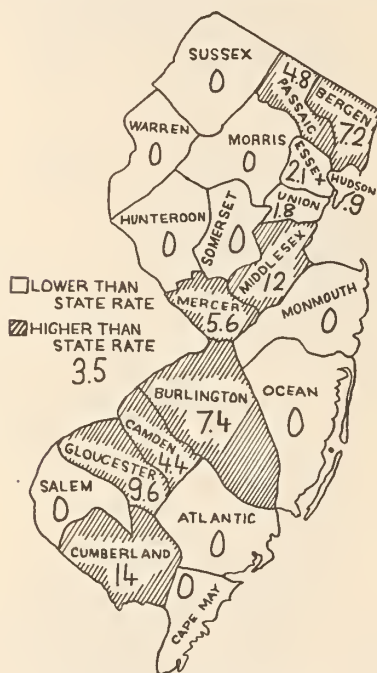
FIGURE 14

### OTHER ACCIDENTS OF CHILDBIRTH

Figure 15. Thirteen counties (60 per cent of the live births in the State) had mortality rates for this classification better than the State average in 1941, and 10 counties (9,630 live births) had no death in this classification. This is a great improvement over any preceding year. The "white" counties had an average

mortality rate of 1.6. These counties had 39,010 live births. The "shaded" counties had a rate of 7.0 per 10,000 live births.

### OTHER ACCIDENTS OF CHILDBIRTH



RATES ARE PER 10,000 LIVE BIRTHS

FIGURE 15

Figure 16. This graph shows the trend in maternal mortality due to other accidents of childbirth for the years since 1931, resulting in a reduction from the rate of 10 per 10,000 to 3.5 per 10,000 live births. The marked reduction in the 1941 rate from this cause was due to improvement in the rate in urban counties (dashes) as the average rate in the rural counties (dotted line) rose slightly. The solid line is the State rate.

More deaths in this classification occurred from *shock* in attempted forceps deliveries followed by version, than in any other complication. Some of the other causes were anesthesia, ruptured uterus, transfusion, and the shock following inversion of the uterus, prolonged labor, and difficult forceps delivery. One patient had six surgical inductions produced on account of toxemia and pyelitis and died of shock. Too much analgesia is a contributing factor in many of the cases dying of shock. Care should

be taken not to use too many varieties of drugs on the same patient.

### OTHER ACCIDENTS OF CHILDBIRTH

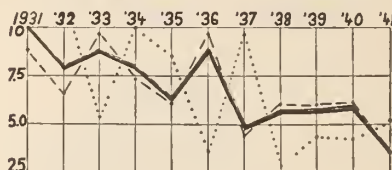
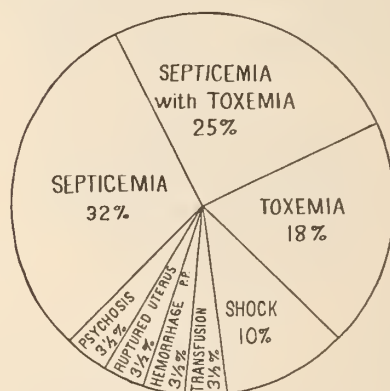


FIGURE 16

### DEATHS following CESAREANS

1941



11 CASES - LABOR - 0  
3 CASES - LABOR - 6 HOURS OR LESS  
3 CASES - LABOR - 17 TO 24 HOURS  
10 CASES - LABOR - 24 HOURS TO 4 DAYS  
1 CASE - LABOR NOT STATED - TOXEMIA

FIGURE 17

### DEATHS FOLLOWING CESAREAN SECTION

Figure 17. The mortality rate for New Jersey in 1941 was 1.8 per cent. The incidence of Cesarean section has dropped to one in 38 deliveries. This incidence varied in hospitals having from one in three deliveries in a small hospital in a rural county where a high percentage is delivered at home, to an incidence of one in 202 in an urban hospital having 1,333 mothers delivered with no deaths. There were 1,526 cesareans done in the State in 1941, according to hospital reports received. Fifty-seven per cent of the deaths following cesareans were due to sepsis. Four of these cases were elective cesareans. Forty-three per cent were toxic before the cesarean; 25 per cent were toxic and died of sepsis following the

cesarean; 75 per cent of the cases which had six or more hours of labor, died of sepsis. One patient died of post-partum hemorrhage. One case had a rupture of uterus two weeks post-partum, when about to go home.

#### ECTOPIC PREGNANCY

Figure 18. This graph brings out the fact that 64 per cent of the women dying with ectopic pregnancy had no operation and therefore had very little chance of recovery. There were five main reasons for this:

1. Patient neglected to send for a physician promptly.

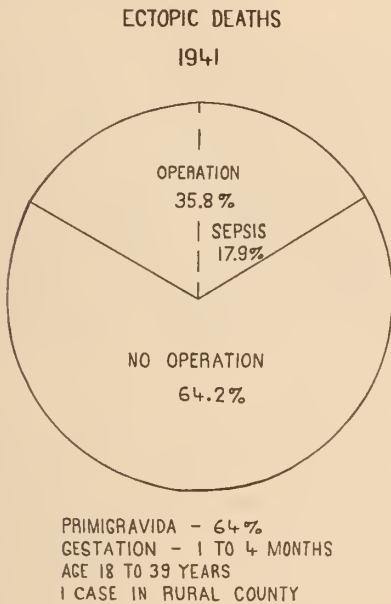


FIGURE 18

2. Patient sent for a physician but refused to follow his advice regarding hospitalization.

3. Patient sent for a physician and was sent to a hospital promptly. She arrived at night, was given a hypodermic of morphine and when seen by the attending physician in the morning was moribund.

4. Patient sent for a physician but correct diagnosis was not made and the autopsy revealed the ruptured ectopic.

5. Patient went to a hospital with a "slow leak" and was watched for a few days. Suddenly she went into shock and died before operation could be done.

This graph also shows that in those who

died following operation, death was due to sepsis in 50 per cent of the cases. Why should sepsis occur in an operation for ectopic pregnancy?

Figure 19. This graph shows that there has been very little change in the mortality rate due to ectopic pregnancy. It also shows that the rural counties (dotted line) have had continuously a lower rate than the State rate while the urban counties (dashes) have had a higher rate than the State.

The study of ectopic histories shows that prompt action in the treatment of these cases is necessary to reduce the mortality rate for ectopic pregnancies.

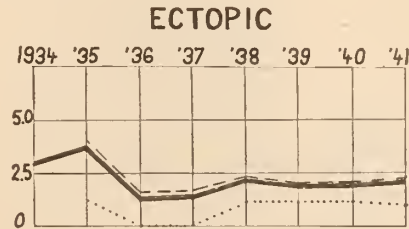


FIGURE 19

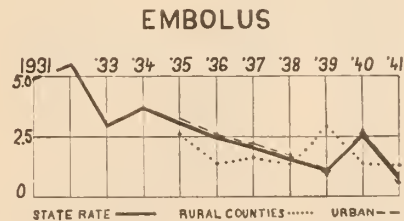


FIGURE 20

#### EMBOLUS

Figure 20. While the new International classification places embolus as a form of septicemia, the State Committee believes that many cases of embolus do not come under this classification; therefore, embolus deaths are kept in a separate group.

The graph shows that in 1940 there was quite a rise in mortality due to this cause and in 1941 the rate dropped slightly below any preceding year. While embolus deaths are considered by many as unavoidable, there is generally some obscure cause due to the patient not being in good condition. One way to avoid deaths from embolus is to see that the patient



is in the best possible condition when labor takes place. This requires careful prenatal care. Complicated labor and deliveries as well as indiscriminate use of drugs contribute towards deaths from embolus.

RECORD OF COUNTIES

Figure 21. This summary indicates the position of the various counties in 1941 in relation to the State rate for each of the five principal

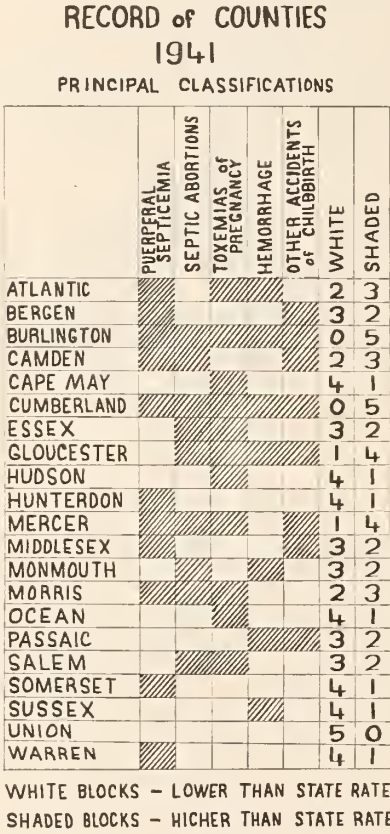


FIGURE 21

causes of maternal death. It is published in order that the physicians of the State may see how their respective counties compare for 1941 with other counties. The picture varies from year to year and in some counties more improvement is shown than in others. The Maternal Welfare Committee of each County Medical Society should study this chart carefully and then take steps to correct any weaknesses which they find.

In checking the average rate of the past six

years for each county regarding the main classifications, we find that Monmouth, Passaic and Salem Counties had the lowest maternal mortality rates, 26 per 10,000 live births for each county. Mercer, Gloucester and Cape May counties had the highest averages.

*Puerperal Septicemia.* Burlington County was lowest, with an average mortality rate of 2.5; Salem County, in second place, had a mortality rate of 2.6; and Passaic County, in third place, had a mortality rate of 3.8. Passaic County had 31,154 live births during this six-year period. The counties with the three highest rates were Sussex, Cape May and Hunterdon.

*Septic Abortion.* Ocean County has had no death in this classification since the septic abortion deaths were made a separate classification in 1933. There were over 4,000 live births in this county during this time. Cape May County has had no septic abortion death in seven years, with a little over 2,000 live births. Middlesex County is in third place with a rate of 1.6 for over 17,000 live births. Warren, Mercer and Gloucester counties had the highest averages.

*Toxemias of Pregnancy.* Warren, Monmouth and Morris Counties had the lowest average rates for six years. Salem, Somerset and Cape May counties had the highest averages.

*Puerperal Hemorrhage.* Hunterdon County has had no death from this cause in nine years. There were over 3,000 live births in this county during this period. Somerset County had no death in seven years with over 6,000 live births for the same period. Gloucester County is next with an average rate of 1.7 and over 5,000 live births. Mercer, Cumberland and Ocean Counties had the highest average rates.

*Other Accidents of Childbirth.* Salem County has had no death in this classification in twelve years with over 7,000 live births. Sussex County has had no deaths in six years with over 3,000 live births. Monmouth County is third with an average rate of 0.7 with over 12,600 live births for six years. Cumberland,

Mercer and Gloucester counties had the three highest averages.

*Embolus.* Hunterdon and Salem counties have had no death in eleven years from this cause. Hunterdon County has had over 4,000 live births and Salem County has had over 6,000 live births during this period. Somerset County has had no death in ten years with over 9,000 live births. Sussex County has had no death from embolus in maternity cases in six years, with a little over 3,000 live births. Bergen County is next with a rate of 0.8 for six years with almost 23,000 live births. Ocean, Gloucester and Cape May counties had the highest average rates.

*Ectopic.* Since 1933, when ectopic deaths were given a separate classification, Burlington County with over 11,700 live births for this nine-year period has had no death in this classification; and Gloucester County with over 8,800 live births for this period has also had no death. Hunterdon, Salem and Warren counties, with fewer live births for this period, also had no death. Somerset County had no death from ectopic pregnancy in seven years with a little over 6,000 live births. Ocean County also had no such death in six years. The next two counties were Monmouth, with over 12,600 live births, and Union County, with over 28,000 live births, each having an average rate of 0.7 per 10,000 for six years. The three highest rates were in Mercer, Camden and Cape May counties.

#### CONCLUSION

A study of these statistics shows that while they are encouraging they can be made better. A study of the histories of maternal deaths discloses many errors in treatment, errors in judgment, errors in technique, and lack of co-operation of the patient.

Patients must understand that they should not simply make an occasional prenatal visit to the physician. They must be impressed with their responsibility to make regular visits and to carry out the physician's directions.

Physicians too, must realize the great importance of preventive prenatal care if they wish to impress upon their patients its value and not pass the subject off in a casual manner. By giving more careful preventive prenatal care much can still be done to reduce maternal mortality. Prenatal care provides for the expectant mother what a course of training gives to the athlete. Many long labors and difficult deliveries can be avoided through properly regulated walking, especially if the fetus remains high in the pelvis during the eighth and ninth months of pregnancy.

Errors in judgment can often be avoided by more frequent and earlier consultations. Errors in technique should be eliminated by more skillful work.

#### OUR GOAL

Adequate prenatal, delivery, and post natal care for every expectant mother in New Jersey.

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## A LESSON FROM A DEATH CERTIFICATE

### NUMBER FORTY-FIVE

Gravida 1, para 0. Patient was first seen when she was 5½ months pregnant. Her blood pressure was 170/100. Urine showed 2+ albumin. Patient was treated actively but after 3½ weeks, her condition remained the same.

Three weeks later her condition was about the same but patient had gained considerable weight. She was advised to enter hospital but did not do so. When 7½ months pregnant she had a convulsion. She was sent to hospital

and treated for eclampsia. Baby, stillborn on the next day. Patient died on the day following delivery.

This is one of many similar cases carried along in the hope of incurring a living child and in the end losing both mother and baby. Were not danger signals present when patient was first seen? Earlier preventive prenatal care might have helped.

A. W. BINGHAM, M.D.

## EXECUTIVE OFFICER'S PAGE

The Trustees and the Welfare Committee both met in September. An abstract of their meetings is published in this issue of *The Journal* for the information of our members. Full recognition was voiced in both meetings and by President Marsh of the fact that the meetings and activities of the Society must be restricted for the duration because of the limited time and personnel available. The reduced income of the State Society due to the credit and refunds given members in service, for dues, and the transportation limitations resulting from gasoline and tire shortage, are also big factors in restricting our activities.

It has been pointed out that in wartime the *government sets the pattern*, and has very wide discretionary powers and direction. It is incumbent upon our Society to conform, insofar as necessary, to this pattern in our activities, except as they relate to our private practice with individual patients who engage the services of their own physician as needed.

In all our *organized* efforts we shall integrate our services with the State and Federal plans in order to secure unity of purpose, and assure health protection to the civilian population by our members who are not already enlisted in the Medical Corps of the Armed Forces.

The response of our men to the call for service with the Army, Navy and other branches of the service is one of which the Society may well be proud. It may be found in fact that in certain areas medical men have been taken into service who might have made a greater contribution at home. Such decisions are difficult to make and no blame can be attached in these cases if such be the situation. A prompt and patriotic response to the call to duty is but natural for men constantly trained to respond to the call for service to humanity.

After reviewing all medical service plans proposed during the emergency we must of course coöperate fully, but we should also continue to think beyond the emergency to the eventual return of peaceful times, and to determine whether such emergency plans for medical service should then terminate, or be revised to better meet the needs of a nation at peace. Wartime is not the time to quibble, but thoughtful consideration and constructive planning for the peacetime conduct and distribution of medical services is equally essential even in wartime.

While the sacrifices of war seem so overwhelming, it takes a true optimist to suggest that some good can also result from such an experience, but we can try to discover ways

and means by which our profession and those we serve might benefit in some definite way from the experiences we shall have gained when peace returns. We shall have learned a lot, as we did in the last war, about improving our professional technics. We can also learn how to widely spread these benefits to those in need thereof, and also how to spread the cost of such services, since this cost is necessarily high if the quality is to be preserved and the greatest benefits are to be provided.

Private practice will definitely continue but *laissez faire* methods are already on the decline, even in medical practice. The growth of the number of hospitalized patients is a reliable criterion of the growing demand for organized services. Pay clinics are on the increase. Trained nurses and technicians, stenographers and other personnel can free the physician from time-consuming and less agreeable tasks so that he may devote his full time to professional procedure where he alone must carry on. This organized and integrated effort of competent persons saves time, cuts costs, increases accomplishment, gives increased satisfaction to those seeking our services, and eventually wins wider public support and commendation for our profession.

The medical profession for the duration of the war will be divided for service into several categories. A large number of our members will join an organized group-service in the Medical Corps of the Army and Navy, which includes the Marines and Coast Guard. The balance will serve in Civilian Defense of war workers and the general public.

Two types of medical service are available in the Civilian Defense program: (1) independent individual private practice; and (2) organized group-service—in industry, in mines, in hospital wards and clinics, in medical and hospital service plans, in governmental plans for various classified groups, such as "the wives and children of enlisted men", "those civilians injured by enemy action", inmates of institutions, and outpatients in hospital clinics.

Wartime is providing on a widespread basis of participation, experience for private physicians to voluntarily serve in organized group-service programs. This experience will do much to acquaint our members with such administrative essentials for insuring organized service as supervision, discipline, time and work schedules, records, etc. Private practitioners are already partly acquainted with these provisions in hospitals where one form of group-service is offered.



## STATE ACTIVITIES

### ADVISORY COMMITTEES AND PERSONNEL

The following Advisory Committee to the Sub-Committee on Public Health of the Welfare Committee has been appointed by President Marsh to embrace certain previous advisory committees of the Public Health Committee:

#### ADVISORY COMMITTEE ON HEALTH SUPERVISION AND PROPHYLAXIS

- Frederic W. Lathrop, *Chairman*, Plainfield
1. Adult Health Supervision
 

William H. Varney, *Chief*, Washington  
Harold A. Kazmann, Long Branch
  2. Child Health
 

Chester R. Brown, *Chief*, Arlington  
Walter B. Stewart, Atlantic City  
Harrold A. Murray, Newark
  3. Cardio-Vascular
 

Harvey M. Ewing, *Chief*, Montclair  
Thomas M. Kain, Camden  
Clarence L. Andrews, Atlantic City
  4. Tuberculosis
 

Abraham E. Jaffin, *Chief*, Jersey City  
Martin H. Collier, Lakeland  
Harold S. Hatch, Morristown
  5. Crippled Children
 

Touffick Nicola, *Chief*, Montclair  
Frederick G. Dilger, Hackensack  
Elmer P. Weigel, Plainfield

The following men have been invited and agreed to serve at the request of President Marsh, whenever called on by the chairman of any of the advisory committees to the Public Health Committee. These men may be called upon directly by the chairmen to serve at such times as their aid is needed.

#### CONSULTANTS TO ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON PUBLIC HEALTH

Frederick W. Brown, New Brunswick  
LeRoy W. Black, Rutherford  
Aaron E. Parsonnet, Newark  
David B. Allman, Atlantic City  
Milton A. Shangle, Elizabeth  
George N. J. Sommer, Sr., Trenton  
Julius Levy, Newark  
Israel J. Wolf, Paterson  
Seth B. Sprague, Jersey City  
Henry Briggs, East Orange  
James P. Pregnall, Asbury Park  
Samuel B. English, Glen Gardner

Marcus W. Newcomb, Browns Mills  
M. James Fine, Newark  
A. Hobson Davis, Paterson  
Enoch Blackwell, Trenton  
George P. Meyer, Camden  
C. Coulter Charlton, Atlantic City  
Leo B. Drake, Bridgeton  
H. Hurlburt Wilson, Bridgeton  
Bart M. James, Newark  
Clarence S. Janifer, Newark  
Wilson G. Guthrie, Newark  
Samuel A. Sandler, Hackensack  
J. Phillip Stout, Jersey City

#### SUBCOMMITTEE ON MEDICAL PRACTICE

The following Advisory Committees to the Medical Practice Subcommittee have been appointed to serve if and when needed:

1. Contract Practice
 

Andrew C. Ruoff, *Chairman*, Union City  
Harvey T. Herold, Newark  
Henry Haywood, New Brunswick
2. Pharmaceutical Problems
 

Chester I. Ulmer, *Chairman*, Gibbstown  
Reeve L. Ballinger, Arlington  
Irving Okin, Passaic
3. Auxiliary Medical Services
 

Sigurd W. Johnsen, *Chairman*, Passaic  
Eugene G. Herbener, Lakewood

#### SCIENTIFIC WORK COMMITTEE

The newly authorized Scientific Work Committee membership is as follows:

First District—John W. Gray, M.D., Newark (1943)  
Second District—William W. Maver, M.D., Jersey City (1943)  
Third District—Patrick H. Corrigan, M.D., Trenton (1943)  
Fourth District—S. Emlen Stokes, M.D., Moorestown (1943)  
Fifth District—Harold Davidson, M.D., Atlantic City (1943)

#### PRESIDENTIAL APPOINTMENTS

Robert A. Kilduffe, M.D., Atlantic City (1943)  
Royce Paddock, M.D., Newark (1944)

(See August *Journal* for the list of Officers and other Committees of The Medical Society for this year. Due to the rapid changes in committee personnel because of inductions into the service, it is advised to consult the Executive Offices, where there will always be an up-to-date list of committee members available.)

## TRUSTEES' MEETING

A meeting of the Board of Trustees was held on September 20, 1942, at the Executive Offices in Trenton. All members were present except three—Dr. McCall, who is in active service with the Armed Forces, and Drs. Young and Crowe.

The Executive Officer, acting as Secretary, announced the acknowledgment by the daughter of Dr. Edward J. Ill of the receipt of the engrossed resolution expressing in the name of the Society the regret of the Trustees at his death.

It was felt necessary for the Trustees to meet once a month during the emergency.

A request from the osteopaths that the Society grant them the M.D. degree, in accordance with the rights granted under our charter, was referred to a committee consisting of Drs. Lee, Marsh and Norton.

The Scientific Work Committee appointments were read and are announced on page 549 of this issue.

It was decided that the names of committee chairmen called into service should be retained, and that the vice-chairmen be appointed as acting chairmen.

President Marsh asked approval of his letter to Dr. Barbash regarding annual registration, which was unanimously given.

An Emergency Fiscal Committee, consisting of Drs. North, Alexander and Londrigan, was appointed by Chairman Lee to review the expenditures of the Society.

The Annual Meeting for 1943 is to consist of a one-day session to be held in Newark in the last week in May, and arrangements are left to the Annual Meeting Committee. This change was due to the fact that all the larger resort hotels in New Jersey have been taken over for the duration, and the limited time, gasoline and tires, make this plan necessary.

Dr. Scott reported that \$3,000 now owed the Medical Preparedness Committee by the Government will make up any deficit that occurs before the end of the fiscal year in the Medical Preparedness Committee budget, and will pay the salary of one of the girls working on Procurement and Assignment who is now paid by The Medical Society. He also reported that to date New Jersey physicians have responded well for service with the Army and

Navy. There are approximately 1,400 men now in service and about 2,000 will be needed by December 31.

Dr. Lewis reported for the Medical-Surgical Plan that 2,898 members are now enrolled. Some claims have already been paid and at present there is a surplus available and it is hoped that by the end of the year 25,000 policies will have been sold. If so, it is unlikely that any financial assistance from The Medical Society will be needed. Of the \$5,000 advanced to the Plan, only \$190.50 has been spent to date.

Dr. Lewis requested the Trustees, or some committee of the Society, to study the proposed commissioning by the U.S.P.H.S. of physicians in New Jersey to man the emergency hospitals established for the care of civilians in the event of disaster. He stated that the proposed service of such physicians was not definitely restricted to their own locality and he felt that the Society should establish a state-wide policy as to the acceptance or rejection of this proposal, since many of the men are apprehensive about accepting such commissions and the establishing of these emergency hospital units. The Society has already approved the commissioning of physicians by the U.S.P.H.S. for purely *administrative* purposes but did not approve commissioning men to deliver medical care to individuals. The appointment of a committee to study this problem and report at the next meeting of the Trustees was unanimously approved.

The Executive Officer was authorized by the committee appointed by the Trustees to move the Executive Offices from the Broad Street Bank Building to 222 West State Street, where the floor space is approximately the same and \$900.00 a year could be saved.

The Chairman of the Finance and Budget Committee reported that 616 members of the Society who are on active duty with the Armed Forces have had their dues remitted or credited to date. This represents a total of \$9,505 charged against the \$16,000 set aside for this purpose in the budget.

The Medical Service Administration was requested to send a monthly statement of expenditures to the Executive Offices in Trenton. Dr. Scott promised this would be done.

The meeting adjourned at 5:20 p. m.

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## WELFARE COMMITTEE MEETING

A meeting of the Welfare Committee was held in Trenton at the Stacy-Trent Hotel on September 27, 1942.

President Marsh again emphasized the necessity for integration of our efforts with those of the government in time of war and the need

for restriction of the less urgent activities of the Society. He pointed out that the Welfare Committee is advisory to the Trustees, who have the executive power. The Welfare Committee is the most representative medical opinion in New Jersey and the Trustees are always anxious, before making their decisions, to hear the majority opinion of the representatives in the Welfare Committee. Dr. Marsh thought that it might be well for the Chairman of the Welfare Committee to appoint a committee to review the question of organization of the committee's work and report back to the Welfare Committee. Dr. Marsh emphasized his belief in the workings of a democratic body and he stated he had no intention of dictating or even attempting to guide the members of the Welfare Committee in reaching their decisions.

Chairman Murphy pointed out the reorganization of some of the advisory committees for the current year on an experimental basis, and emphasized the power of the government through legislation and presidential decree to cut the pattern for all activities, and since we are all doing our best to assist government in war time we will conform for the duration. He stated, however, that we should always review all governmental orders with a view to the future set-up, with the very definite purpose of determining whether such activities should be continued, revised or discarded in peacetime.

The Secretary reported on the unfinished business to come before the committee, and Dr. Decker, Chairman of a special committee on "Medical Care for the Wives and Children of Enlisted Men in the Armed Services", reported for his committee, stating that a start of the operation of the plan is to be made in South Jersey, because the limited funds will not permit the state to be covered as a whole, and the Department of Health, through whom the funds are made available by the government, felt that the facilities were least and the need greatest in this part of New Jersey. Fees proposed were \$35 for home obstetrical cases and \$25 for hospital deliveries. Details of the plan were worked out by the Consultant of the Maternal and Child Health Bureau of the State Department of Health upon whom the responsibility was fixed by the government. Tentative details of the plan were discussed and several criticisms were offered but the general plan had already been previously approved. Among those who discussed this plan were: Drs. Fields, Hawkes, Ulmer, Nichols, Way, Schaaf and Burkett.

In reporting for the subcommittees, Dr. Polak, Chairman of the Committee on Legisla-

tion, emphasized the increasing need for a paid executive to carry on the work of the Society and the committee, and pointed out some of the achievements of the past year which the Legislative Committee had reported, and some of the problems of the immediate future.

Dr. Nichols reported that the general aim of the Public Health Committee was to concentrate on essential things for the duration of the war and lay aside nonessentials, and to integrate and operate, in closest coöperation with other health professions and agencies in this State, the health work for the duration. Dr. Nichols asked each of his advisory committee members to take one specific urgent objective and concentrate upon it with the aim of accomplishment during the current year. He spoke of the conference of seven public health agencies acting through the Conference of Allied Medical Professions in support of the Governor's invitation to the United States Public Health Service to make suggestions for the improvement of public health administration in New Jersey.

Dr. Decker, speaking for the Medical Practice Committee, stated that their present objective for the year was to discuss and better define the term "adequate medical care", but beyond this he felt the committee would be prepared to meet and attempt to solve any problems that arose in which their participation was desired.

Dr. Schaaf spoke of the curtailment of activities for the duration as they related to Public Relations and suggested a coöperative effort between the Essex County Society Public Relations Committee and that of the State Society as it relates to newspaper publicity. He stated that his committee had not yet met but would present a brief program at the next meeting of the Welfare Committee.

In closing, Dr. Marsh urged each member of the Welfare Committee to report back to his county society the proceedings of the meeting as part of their responsibility as members of the committee.

Dr. Read, the Chairman, having been called into service, the Vice-Chairman, Dr. Murphy, has been officially appointed as Acting Chairman to carry on the work and a new Vice-Chairman will be appointed by President Marsh before the next meeting.

Those present were: Chairman Murphy, President Marsh, Secretary Wilkes, 24 members representing all the counties except Burlington, Morris and Salem, and the following guests: Drs. Glen Usher, Robert Fischelis, E. Zeh Hawkes, Ralph Hollinshed and Watson B. Morris.

The meeting adjourned at 4:15 p. m.



## INDUSTRIAL MEDICINE

### COMMITTEE ON INDUSTRIAL HEALTH

J. M. CARLISLE, M.D., Chairman

The unparalleled increase in manufacturing activity entailed by the War Program is bringing new health problems to industry and making the solution of many of the old ones more difficult. Among the conditions that tend to lower the workman's efficiency and to increase accidents and illness the following are typical:

1. Taking "short cuts" in (a) the selection of personnel, (b) in the application of safety measures, and (c) in the medical care and supervision of employees. These chances are taken due to the inability of the several services to keep up their personnel standards under the demands for rapid physical expansion.

2. Assignment of inexperienced or unskilled workers to unfamiliar situations, usually due to any of three factors:

- a. Shortage of skilled workmen.
- b. Lack of adequate apprentice systems.
- c. Loss of skill by workers long unemployed.

3. Introduction of potentially dangerous substances new to the plant's experience.

4. Speeding up of machines on the production line, or stepping up processes, safe at the normal rate, to a point where they become hazardous.

5. Improper ventilation and inadequate lighting of plant.

6. Longer hours of work.

7. Fatigue, which lowers efficiency, accuracy, and the capacity for attention.

8. Overcrowding of workers in the plant.

9. Inadequate and crowded community living conditions.

10. Increased employment of less experienced women and physically unfit men.

11. Lack of attention to nutrition, especially needed for workers under increased physical strain.

To combat these adverse conditions, it is of prime importance for the industrial physician to ascertain by preplacement examinations, the physical and mental fitness of the applicant for the specific job in view. Thus, both management and labor may then feel assured that no employee will be assigned to work that will place undue strain on his capacities.

It is equally important that the health and

efficiency of persons already employed should be maintained and improved. *Periodic re-examinations* should be conducted at suitable intervals in order to detect any illness or disease in its early stages and to institute the necessary prophylactic or therapeutic measures.

Important as these steps are, however, they represent only half the battle. If the objectives of industrial health and hygiene programs are to be achieved, it is necessary also to direct attention to the plant itself. In the inspection and study of the plant and working environment, as in other departments of industrial medicine, *the coöperation of the plant engineer, the chemist, and the industrial nurse must be sought*. The aim should be to establish and maintain the following essentials:

1. Clean, well-ventilated, adequately lighted working quarters, with proper temperature and humidity controls.

2. Protective clothing, respirators, masks, goggles, etc., where needed.

3. Maximum safety in machines, processes and procedures.

4. Safe working tools.

5. Hygienic wash rooms, locker rooms, rest and lunch rooms.

6. Adequately equipped rooms for medical examination, first aid, and emergency treatment.

7. Medical, accident, and absentee records.

These should be supplemented by the following procedures:

- a. Program of accident prevention.

- b. Program of fatigue prevention.

- c. Provisions for recreational or athletic activities.

- d. Periodic check-up on illumination, ventilation (as related to removal of dust, fumes, and gases), temperature, and humidity.

- e. Hospital and medical insurance to provide adequate care for employees.

- f. Employees' mutual benefit associations.

- g. Health and hygiene educational program.

- h. Program of nutritional improvement.

By thus expanding the scope of his activities, the industrial physician may secure the highest degree of efficiency from a limited personnel during the present emergency.

## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ABEL, MARGARET (Neptune)—See Pons, C. A.

BANG, FREDERICK B. (Princeton), Dept. of Animal and Plant Pathology of Rockefeller Institute for Medical Research

Experimental infection of the chick embryo with the virus of pseudorabies. *J. Exper. Med.*, 76:263-269, Sept. '42

BOURGEOIS, GEORGE A. (Jersey City)

Identification of fetal squamas and the diagnosis of ruptured membranes by vaginal smear. *Am. J. Obst. & Gynec.*, 44:80-87, July '42

CANNON, E. A.; W. H. MODARELLI, F. R. DE VINCENZO and M. SWINEY, III (Hoboken)

Treatment of delirium tremens. *J. A. M. A.*, 119: 1418, Aug. 22, '42

CARDWELL, E. P. (Newark)—See Loeser, L. H.

CLARK, JOSEPHINE D. (Rahway)—See Unna, Klaus

COMANDO, HARRY N. (Newark)

Tuberculosis of the thyroid gland with hyperthyroidism: case report. *Am. J. Surg.*, 57:356-358, Aug. '42

DE VINCENZO, F. R. (Hoboken)—See Cannon, E. A.

FLICKER, DAVID J. (Camp Blanding, Fla.)

1. Army psychiatric literature, factors in interpretation. *Am. J. Psychiatry*, May '42

2. (with Olon H. Coleman)—Medical discharges from military service, a report of six hundred cases. *New England Jour. Med.*, June 11, '42

GORDON, MAURICE BEAR (Atlantic City)

Hippiatric texts from ugarit. *Ann. Med. Hist.*, 4:406-408, Sept. '42

KERN, E. CLARENCE (Montclair)

Use of sulfanilamide and gauze packing following intranasal operation. *Arch. Otolaryng.*, 36: 134, July '42

KILBORN, MELVILLE G. (West Orange)—with SYLVAN E. FORMAN, Ph.D.; WILLIAM E. EVANS, JR., Ph.D., and JOHN C. KRANTZ, JR., Ph.D.

Anesthesia VII. Studies with cyclopropyl ethyl ether (cypreth ether) in man. *Anesthesiology* 3: 414-417, July '42

LOESER, L. H., and E. P. CARDWELL (Newark)

Elongated styloid process; a cause of glossopharyngeal neuralgia. *Arch. Otolaryng.*, 36:198-202, Aug. '42

MARTIN, STEVENS, MAJOR (M.C.) U.S.A. (Fort Dix)

1. Instruction in anesthesiology at Tilton General Hospital. *Anesthesiology*, 3:433-436, July '42

2. Teaching of anesthesiology in the army. *J. A. M. A.*, 119:1245-1248, Aug. 15, '42

MODARELLI, W. H. (Hoboken)—See Cannon, E. A.

NAYLOR, MILDRED V., Librarian, Academy of Medicine (Newark)

1. Henry Leber Coit: A Biographical sketch. *Bull. Hist. Med.*, 12:367-376, July '42

2. How to advertise your library. *Bull. M. Library A.*, 30:327-332, July '42

NELSON, JOHN B., Ph.D. (Princeton)—From Dept. of animal and plant pathology of Rockefeller Institute for Medical Research

Reciprocal transmission tests with infectious catarth of chickens, mice and rats. *J. Exper. Med.*, 76:253-262, Sept. '42

PONS, C. A. (Asbury Park)

1. Cellophane cover slips. *Am. J. Clin. Path.*, 12: 57, July '42

2. (with MARGARET ABEL, Fitkin Memorial Hospital, Neptune)—Error in sulfanilamide determination due to novocaine. *Am. J. Clin. Path. Tech. sec.*, 12:53-54, July '42

RABE, RUDOLPH F. (Basking Ridge)

What is the future of the homeopathic school? *J. Am. Inst. Homeop.*, 35:379-381, Aug. '42

SWINEY, M. (Hoboken)—See Cannon, E. A.

UNNA, KLAUS, and JOSEPHINE D. CLARK (Rahway)

Effect of large amounts of single vitamins of the B group upon rats deficient in other vitamins. *Am. J. Med. Sci.*, 204:364-371, Sept. '42

## STUDY OF NEW JERSEY'S HEALTH NEEDS AND ORGANIZATION

At the request of Governor Edison the United States Public Health Service is making a study of New Jersey's health needs and organization. Surgeon-General Parran has assigned to this work Dr. Ralph C. Williams, Senior Surgeon and Director of the United States Public Health Service District No. 1, with headquarters in New York. The study was sponsored by a Health Conference Committee composed of groups in the Governor's Health Conference of two years ago and con-

sisting of representatives of The Medical Society of New Jersey, New Jersey State Dental Society, New Jersey Pharmaceutical Association, New Jersey State Nurses Association, New Jersey Health Officers Association, New Jersey Health and Sanitary Association and the New Jersey Welfare Council. Dr. Stanley Nichols of Long Branch was appointed Chairman of this committee. Their first move was to make an offer of coöperation to Governor Edison who promptly accepted this offer.

## A RESOLUTION BY THE TRUSTEES OF THE MEDICAL SOCIETY OF NEW JERSEY

*Whereas*, In the death of Edward J. Ill, M.D., of Newark, the medical profession has lost a physician whose conduct was exemplary, and the people of New Jersey a zealous and humane friend; and

*Whereas*, The Medical Society of New Jersey has lost its oldest and most beloved member whose devotion to its work continued unabated whether he served as member, President or Fellow; and

*Whereas*, The science of medicine has lost a source of contributions born of a fruitful and

industrious life, and the young physician a favorite teacher; therefore

*Be It Resolved*, That the Trustees speaking for The Medical Society of New Jersey, express their thanks to God for Dr. Ill's long life among us and their sorrow at his death; and

*Be It Further Resolved*, That a copy of this resolution, suitably engrossed, be sent to the family of Dr. Ill in whose loss the Society sympathizes.

(Signed) THOMAS B. LEE, M.D.,  
Chairman.

The above resolution, drafted by a committee of the Trustees, was suitably engrossed and sent to Dr. Ill's daughter, Mrs. Scheller, as directed by the Board of Trustees, and the following letter of appreciation was received from Mrs. Scheller:

To The Medical Society of New Jersey  
Dear Doctor Wilkes:

My family will hold in grateful remembrance your fine tribute to our father, Dr. Edward J. Ill.

Your kindness and thoughtfulness to Father, to his last living day will always be a cherished memory to me.

Kindly convey to the members of The Medical Society of New Jersey our sincere thanks and deep appreciation.

Very sincerely,  
CLOTHILDE ILL SCHELLER.

September 15, 1942.

## MEDICAL CARE OF WIVES AND CHILDREN OF ENLISTED MEN

On September 28, 1942, in the City Hall in Camden, a meeting was held to which representatives of The Medical Society, hospitals, nursing organizations and others were invited.

Dr. Julius Levy, Consultant to the Maternal and Child Health Bureau of the State Department of Health, presented the aims, purposes, procedures, allowances and required records which will be used in connection with the Federal project to provide medical services for the wives and children of enlisted men in the Armed Forces of the United States, when such wives and children cannot afford to provide such medical services for themselves. This subject was previously discussed with the Chairman of the Medical Practice Subcommittee of the Welfare Committee, the Chairmen of the Maternal Welfare, Public Health and Child Health Committees of The Medical Society at a meeting in Newark in the early summer of this year, and approval was given to the conduct of this experiment with Federal funds, as proposed by the Federal Government and legalized by Congressional action under the Social Security Act under Title 5. This provision was made at the request of President Roosevelt and was sponsored in Congress by Senator George of Georgia and Representative Doughton of North Carolina.

The money is made available through the Children's Bureau and by them to the official state departments of health in the country. In New Jersey the funds available (\$10,000.) are limited and will be used mostly in the more rural areas where facilities for those to whom the benefits are offered are not as readily available as in the urban areas.

The State Medical Society representatives have approved this program and it is a part of our wartime obligation to integrate our efforts with those of the Federal Government in carrying out the provisions made by Congress to help protect the health of the soldiers' wives and children during the emergency. This is a new departure in distribution of group service, but there are already new departures in medical practice now functioning in our State, and more are likely yet to come. The medical profession will do its full share to relieve the minds of our enlisted men regarding medical care available to their wives and children. Details of the procedure can be learned from the Bureau of Maternal and Child Health of the State Department of Health in Trenton. The forms tentatively prepared are available on application to Bureau of Maternal and Child Health, Room 430, Broad Street Bank Building, Trenton, N. J.



## QUININE RESTRICTIONS

### FROM THE COMMITTEE ON PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown, N. J.

Due to war necessity, the War Production Board recently issued an order restricting the use of quinine and other cinchona derivatives. A statement issued with the order indicates that the available supply of quinine required for civilian and military needs is so small as to warrant the issuance of the restrictive order.

The drugs placed under restriction include cinchona bark and its alkaloids, quinine, cinchonidine, cinchonine, quinidine, etc. Those principally included in the physician's armamentarium would be quinine (any of its salts) and quinidine.

Under the restrictive order, quinine may not be distributed or used by anyone unless it is for anti-malarial use. This restriction also applies, of course, to cinchona or any of its alkaloids and salts. In the case of quinidine, the restrictions are extended to include its use for cardiac disorders.

In consequence of the edict, physicians are forbidden to prescribe any of these substances unless they are intended for the use to which they have been restricted. Plans are now being made to collect whatever stocks of these materials are on hand in drug stores, to be applied to a pool from which they will be distributed to wherever urgently needed for the control of malaria. Consequently, there should be adequate supplies available for physicians' use in the treatment of the illness to which their use has been restricted. However, none will be available for use in the compounds many physicians have been using for the treatment of other ailments.

This is brought to the attention of New Jersey physicians in order that they may cooperate with the government in its effort to conserve the supplies of these medicines which are so highly essential for the welfare of the nation in its war effort.

## NEWARK OFFICES OF THE MEDICAL SOCIETY

To clarify some confusion which seems to exist in the minds of some of our members, attention is called to the fact that Medical Service Administration, which operates the Farm Security Plan and Medical-Surgical Plan (for hospitalized patients) has an office supported by The Medical Society at 31 Clinton Street, Newark. Dr. Norman M. Scott is located at this address.

Procurement and Assignment work conducted under Dr. Charles Schlichter's direction in New Jersey, with the assistance of Dr.

Scott, is also handled from the Newark office. While Dr. Scott is technically the Executive Assistant to The Medical Society of New Jersey, all communications regarding the above three services should be directed to him at the Newark Office, and not through the Executive Officer of the Society in Trenton, since Dr. Scott is given full-time leave to conduct these projects for the Society.

The telephone number of the Newark office is Mitchell 2-0675.

## MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES

### SUPPLEMENTARY LIST NUMBER FIVE

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Arons, Harry, Elizabeth (7)  
Babbitt, Hugh M., Jr., Plainfield (20)  
Baiocchi, Pascal J., Newark (7)  
Barolsky, Benjamin, Paterson (16)  
Baruch, Rudolph J., Elizabeth (20)  
Berenson, Samuel J., Elizabeth (20)  
Bew, Richard C., Atlantic City (1)  
Black, Maskell B., Glassboro (8)  
Blatt, David, Elizabeth (20)  
Block, Milton, Irvington (7)

Bolanowski, Kasimier J., Elizabeth (20)  
Bourns, Edward G., Westfield (20)  
Bremer, Kenneth M., Maplewood (7)  
Breslow, Alexander E., Rahway (20)  
Burkett, J. Paul, Woodbury (8)  
Burststein, Frank, Newark (7)  
Butenas, Joseph J., Elizabeth (20)  
Cameron, C. Paul, Ocean City (5)  
Caldwell, Donald M., East Orange (7)  
Castaldo, Neil, Cranford (20)

- Chalfant, W. Paxson, Jr., Ventnor (1)  
 Charney, William, Paterson (16)  
 Cheskin, Louis J., Newark (7)  
 Cohen, M. Maurice, Paterson (16)  
 Colavita, James J., Trenton (11)  
 Colmer, M. Jonas, Newark (7)  
 Conserva, Peter V., Clifton (16)  
 Crane, Bernard, Atlantic City (1)  
 Crane, Norman T., Plainfield (20)  
 Crankshaw, Orrin F., Summit (20)  
 Cronin, Francis J., Elizabeth (20)  
 Del Mauro, Alphonse, Paterson (16)  
 Demarest, Gerald B., Westfield (20)  
 DiFino, Felix, Newark (7)  
 Doktor, David, Paterson (16)  
 Doranz, Harold K., Trenton (11)  
 Eames, William N., Trenton (11)  
 Ehrlich, Max, Elizabeth (20)  
 Esposito, Anthony L., Clifton (16)  
 Esty, Geoffrey W., Westfield (20)  
 Feinstein, Louis, Atlantic City (1)  
 Finkelstein, Abe S., Newark (7)  
 Gadomski, Casimir F., Elizabeth (20)  
 Geiger, Harold, West Milford (16)  
 Gelman, Sidney, Paterson (16)  
 Gilpin, Fletcher, Cranford (20)  
 Glass, Harry L., Plainfield (20)  
 Goldenberg, Raphael R., Paterson (16)  
 Goldstein, Samuel, Mays Landing (1)  
 Gonczy, Edward J., Elizabeth (20)  
 Gordon, Samuel, Paterson (16)  
 Grossblatt, Philip, Newark (7)  
 Gruhler, Jean A., Ventnor (1)  
 Grunt, Louis, Newark (7)  
 Guarraia, Joseph, Hawthorne (16)  
 Guertin, Diomedes, Skillman (18)  
 Gurnee, Quinby D., Hawthorne (16)  
 Halpern, Samuel, Atlantic City (1)  
 Hayman, Irving R., Paterson (16)  
 Hersohn, William W., Atlantic City (1)  
 Hess, George A., Titusville (11)  
 Higgins, Thomas F., Elizabeth (20)  
 Hillmann, Frederick C., Paterson (16)  
 Hofer, William R., Camden (4)  
 Hoffman, Charles A., Plainfield (20)  
 Hoffman, Harry, Atlantic City (1)  
 Holoman, M. Browne, Margate (1)  
 Hunter, Floyd D., Hamilton Square (11)  
 Jehl, Joseph R., Clifton (16)  
 Joffe, Sidney H., Paterson (16)  
 Jones, Herbert E., Elizabeth (20)  
 Jones, Lewis H., Roselle Park (20)  
 Kaletkowski, Marion, Passaic (16)  
 Kline, Herman, Atlantic City (1)  
 Kohn, Leo, South Orange (7)  
 Krieger, George, Passaic (16)  
 Laurie, Andrew L., Elizabeth (20)  
 Leonard, Isaac E., Jr., Atlantic City (1)  
 Liana, Stephen M., Paterson (16)  
 Lieb, Saul, Newark (7)  
 Lieberman, Milton L., Roselle Park (20)  
 Lipton, Louis, Passaic (16)  
 Lynch, Edward T., Elizabeth (20)  
 Mackler, Meyer, Paterson (16)  
 Maggio, Ross J., Westfield (20)  
 Magill, Marcus, Atlantic City (1)  
 Major, Morton M., Atlantic City (1)  
 Martin, Theodore, Glen Rock (16)  
 Marvel, Peter H., Northfield (1)  
 McCracken, Josiah C., Jr., Ventnor (1)  
 Merendino, Anthony G., Atlantic City (1)  
 Merlo, Francis V., Elizabeth (20)  
 Miller, Samuel, Pennington (11)  
 Murphy, Thomas W., Short Hills (7)  
 Nataro, Joseph, South Orange (7)  
 Newman, Julius, Newark (7)  
 Nussbaum, Joseph, Elizabeth (20)  
 Oppen, Philip, Paterson (16)  
 Owen, Philip, Union (20)  
 Pasternack, Elroy, Passaic (16)  
 Perez, John F., Atlantic City (1)  
 Pollack, Louis, Elizabeth (20)  
 Rieck, Allan, Pleasantville (1)  
 Rosenberg, Louis, Atlantic City (1)  
 Rubba, Russell R., Hammonton (1)  
 Santangelo, Emil, Paterson (16)  
 Schweizer, Roman G., Elizabeth (20)  
 Senerchia, Fred F., Jr., Elizabeth (20)  
 Sexton, Edward V., Teaneck (2)  
 Shavelson, Irving, Atlantic City (1)  
 Shechner, Isadore, Newark (7)  
 Sherman, Samuel H., Elizabeth (20)  
 Shuster, Samuel A., Atlantic City (1)  
 Singley, Harry P., Jr., Ventnor (1)  
 Small, Louis, Passaic (16)  
 Solomon, Harold, Newark (7)  
 Stein, George H., Elizabeth (20)  
 Stern, Morris H., Clifton (16)  
 Steuart, David F. R., Summit (20)  
 Stewart, Sloan G., Atlantic City (1)  
 Thompson, Edward C., Paterson (16)  
 Timberlake, Baxter H., Atlantic City (1)  
 Tomec, Richard F., Cape May (7)  
 Vitolo, Ralph E., Linden (20)  
 Volpe, Donald J., Hammonton (1)  
 Wacker, William F., Hillside (20)  
 Walker, Levi M., Atlantic City (1)  
 Weissman, Meyer T., Elizabeth (20)  
 Whims, Clarence B., Ventnor (1)  
 Williams, Leonard D., Plainfield (20)  
 Wilner, Irving, Trenton (11)  
 Winn, Samuel L., Atlantic City (1)

## SUPPLEMENTARY LIST OF MEMBERS NUMBER SIX

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### ACTIVE MEMBERS

- Barberio, A. Arthur, 1337 Orange ave., Union (20)  
 Christensen, Osborne D., 315 Terrace av., Hasbrouck Heights (2)  
 Farley, Raymond F., Clinton (10)  
 Fisher, Percy C., 145 Franklin av., Ridgewood (2)  
 Gordon, Sarah, 327 Cedar lane, Teaneck (2)  
 Kanning, Fred'k R., 47 W. Allendale av., Allendale (2)  
 Kingman, John G., Wyckoff (2)  
 Kosminski, Louis, 30 W. Edsel Blvd., Palisades Park (2)  
 Lease, Henry J., 111 74th st., Woodcliff (9)  
 Levitas, Irving M., 199 Fairview av., Westwood (2)  
 Mango, Concetta G., 435 79th st., N. Bergen (9)  
 Pasternack, Elroy, Hdqs., Governor's Is., N. Y. (16)  
 Pindar, Irene D., 627 Queen Anne rd., Teaneck (2)  
 Reason, John J., 612 Roosevelt av., Carteret (12)  
 Rooks, Wendell H., Wyckoff (2)  
 Shechner, Isadore, 80½ Third av., Newark (7)  
 Volpe, Donald J., Marine Barracks, c/o Tank Park, New River, N. C. (1)

## ● THE BULLETIN BOARD ●

### MEETINGS

The Cumberland County Medical Society will meet on *October 13* at 2:30 p. m. (dinner at 4:00 p. m.) in the Administration Building, Vineland State School, Vineland, N. J. Drs. Margaret E. Shirlock and Sonia Cheifetz will present "Clinic Types". Dr. Ralph K. Hollinshed, President-Elect of The Medical Society of New Jersey, will be the guest of honor.

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On *October 15* Major Henry Cotton, Psychiatrist, stationed at the Tilton General Hospital at Fort Dix, N. J., will address the members of the Morris County Medical Society on "Psychiatric Problems in the Armed Forces". The meeting will be held at the Greystone Park State Hospital, Morris Plains, at 8:45 p. m.

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Dr. Philip M. Stimson, Assistant Professor of Pediatrics, Cornell University Medical College, New York City, will speak on "Early Treatment of Poliomyelitis with a Demonstration of the Kenny Technics" at the *November 12* meeting of the Essex County Medical Society. The meeting will be held in the Academy of Medicine, Newark, at 9:00 p. m.

• • •

The Annual Meeting of the Sanitary Association will be held on *October 23, 1942*, at the Stacy-Trent Hotel in Trenton. "Civilian Health in War Time" will be the theme of the meeting.

• • •

The 71st Annual Meeting of the American Public Health Association will be held at St. Louis, Mo., *October 27-30, 1942*.

• • •

The meeting of the New Jersey Welfare Council will be held on *November 12 and 13, 1942*. The place of the meeting has been changed due to the fact that the hotel in Asbury Park was taken over by the government. The place tentatively selected is Trenton, if accommodations can be satisfactorily arranged. Mr. Dreyfuss, Director of the State Defense Council, will be one of the principal speakers.

### A. M. A. 1943 ANNUAL MEETING

After prolonged and intensive consideration, the Board of Trustees of the American Medical Association has come to the conclusion that the annual session of the Association scheduled to be held in San Francisco in 1943 should be cancelled. An official announcement to that effect will appear in The Journal of the American Medical Association. This decision of the Board of Trustees was made after securing the best available official information and after thorough consideration of the many factors involved.

An official meeting of the House of Delegates of the American Medical Association will be held in Chicago at a time to be announced.

The Annual Conference of Secretaries of Constituent State Medical Associations will be held at the Association's offices in Chicago on November 20 and 21 for the purpose of discussing existing problems and problems that may develop as the result of the intensification of the war program. Your kindness will be greatly appreciated if you will suggest topics for the Conference program. It is the desire of the Board of Trustees and of other officers of the American Medical Association that the program pertain to matters of important common interest and it is hoped that the papers and discussions presented before the Conference can be made as helpful as possible to secretaries, editors and other officials of the constituent state medical associations.

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### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 13, 1943, at 2:00 p. m. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh (6), Pennsylvania, by *November 16, 1942*. Application blanks and further information may be secured from Dr. Titus.



### COLUMBIA UNIVERSITY POST-GRADUATE COURSES

Post-graduate Courses in Clinical Medicine in 20 subjects will be given at the Mount Sinai Hospital Fifth Avenue and 100th Street, New York, as:

1. Part-time courses — October-December, 1942; February-March, 1943.
2. Intensive full-time courses—Cardiology, April 5-May 1, 1943; gastroenterology, April 5-May 1, 1943.

### AMERICAN BOARD OF OPHTHALMOLOGY

Because of the war emergency, the Board announces the following additional examinations:

NEW YORK CITY—*December 13th to 16th*  
LOS ANGELES—*January 15th and 16th*

At the last meeting it was decided to cancel the 1943 written examination, to include in the oral examination all of the subjects previously covered by the written examination, and to temporarily dispense with the requirement of case reports. The oral examination will probably require two or three days and will cover the following subjects:

External Diseases—Slit Lamp  
Ophthalmoscopy  
Histology—Pathology—Bacteriology  
Ocular Motility  
Refraction—Retinoscopy  
Practical Surgery  
Anatomy and Embryology  
Perimetry  
Therapeutics and Operations  
Optics and Visual Physiology  
Relation of the Eye to General Diseases

Formal application on the proper blanks for the December and January examinations must be filed with the Secretary not later than November 1st.

Please write at once for blanks to: American Board of Ophthalmology, 6830 Waterman Avenue, St. Louis, Mo.

### FIFTEENTH GRADUATE FORTNIGHT

The New York Academy of Medicine announces that the Fifteenth Graduate Fortnight, to be conducted *October 12 to 23, 1942*, will be devoted to "Disorders of the Nervous System". The program includes morning panel discussions, afternoon clinics, evening lectures, scientific exhibits and demonstrations. There is a registration fee of \$5.00 for the entire course.

A complete program may be obtained by

writing to the New York Academy of Medicine, 2 East 103rd Street, New York City.

### TOWN HALL OF ESSEX COUNTY PROGRAM

The Academy of Medicine, one of the co-operating organizations, profits financially by all tickets sold through its committee. When you buy, simply mention the Academy. In addition you may be solicited on the 'phone by representatives of the committee. Seats may be obtained either for the series or for individual programs.

H. V. Kaltenborn, NBC news analyst, will be first speaker in the fourth annual lecture series. He will talk October 26 on "Are We Winning the War?"

The second program, scheduled for November 16, will be a symposium on "Whither America—Politically, Economically, Socially?" Mayor LaGuardia, Stuart Chase, author and economist, and Dr. Harry Overstreet, Columbia University professor, will discuss the subject.

F. P. Adams, newspaperman and quiz expert of "Information, Please", will take the platform December 14 with "Innocent Merriam" as his subject.

Three religious leaders will discuss "The Postwar World" February 15. They are Mgr. John A. Ryan, director of social action for the National Catholic Welfare Conference; Dr. Ralph W. Sockman, pastor of Christ Methodist Church in New York, and Rabbi Milton Steinberg of Park Avenue Synagogue in New York.

Representing art, literature, drama and music, four contemporaries in those fields will discuss "The Effect of the War on the Arts" March 8. The speakers will be John Mason Brown, drama critic of The New York World-Telegram; Malvina Hoffman, author and sculptress; Jan Struther, creator of "Mrs. Miniver", and Deems Taylor, music consultant of the Columbia Broadcasting System.

*Subscription for the series*—\$2.20, \$3.30, \$4.40, \$5.50 (tax included); all seats reserved. A question period will be a part of every program. All sessions will begin promptly at 8:40 p.m. at the Mosque Theatre, 1020 Broad Street, Newark, N. J.

### NEW GONORRHEA LABORATORY SERVICE

The Laboratory of the State Department of Health is now doing Gonococcus cultures. This new procedure greatly increases the accuracy of the laboratory diagnosis of gonorrhea. Another milestone in the conquest of venereal diseases.

# COUNTY MEDICAL SOCIETIES OF NEW JERSEY

DATES OF MEETINGS, SEPTEMBER, 1942—JULY, 1943

County	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic	11	9	13	11	8	12	12	9	14	..	..
Bergen	8	13	10	8	12	9	9	13	11	8	..
Burlington	10	8	12	10	14	11	11	8	13	..	..
Camden	..	6	3	1	5	2	2	6	4	..	..
Cape May	..	13	10	8	12	9	9	13	11	..	..
Cumberland	..	13	..	8	..	9	..	13	..	8	..
Essex	..	8	12	10	14	11	11	8	13	..	..
Gloucester	17	15	19	17	21	18	18	15	20	..	..
Hudson	..	6	3	1	5	2	2	6	4	..	..
Hunterdon	..	27	..	..	26	..	..	27	..	..	27
Mercer	..	14	11	9	13	10	10	14	12	9	..
Middlesex	..	21	18	16	20	17	17	21	19	16	..
Monmouth	30	28	25	23	27	24	24	28	26	23	..
Morris	..	15	..	17	..	..	18	..	..	17	..
Ocean	Meets at call of President										
Passaic	..	27	17	15	19	16	16	20	18	..	..
Salem	18	16	20	18	15	19	19	16	21	..	..
Somerset	..	8	12	10	14	11	11	8	13	10	..
Sussex	Meets at call of President										
Union	9	..	11	..	13	..	10	14	12	..	..
Warren	..	20	..	..	19	..	..	20	..	..	20

## COUNTY SOCIETY REPORTS

## BERGEN COUNTY

Reported by F. Edward Whitehead, Executive Secretary

The regular meeting of the Society was held at Bergen Pines, Bergen County Hospital, on September 8, 1942. There were over 100 present. The meeting was called to order by the President, Dr. HENRY D'AGOSTIN, at 9:00.

During the brief business meeting the following were elected to Junior Membership:

- DR. MARGARET GALOTTA, Hackensack
- DR. ALBERT HAGOVSKY, Carlstadt
- DR. MIECZYSLAW J. BROZNA, East Rutherford
- DR. GEORGE F. DOYLE, Englewood

The scientific meeting consisted of a *Poliomyelitis Symposium*. DR. PASCAL F. LUCCHESI, Medical Director and Superintendent of the Hospital for Contagious Diseases, Philadelphia, was the principal speaker of the evening. He discussed the "Epidemiology of Poliomyelitis", the orthodox "treatment" and the Sister Kenny treatment. It seemed to be the consensus of opinion that the respirator still has a place in the treatment of poliomyelitis.

DR. SEAGRAVE and her assistants, of the Medical Staff of Bergen Pines, gave a very interesting and instructive demonstration and discussion of the Sister Kenny method of treatment.

DR. FREDERICK DILGER, Attending Orthopedist at Bergen Pines, stressed in his talk some of the highlights of rehabilitation of the poliomyelitis cripple.

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The first meeting of the *Burlington County Medical Society* was held on September 10, 1942, at the Burlington County Hospital in Mt. Holly. PRESIDENT PARRY SCOTT presided and welcomed Dr. LLOYD GREENE of Philadelphia.

Due to the changed conditions the Executive Committee of this Society has decided that the meetings in September, November, January, March and May will be solely for the transaction of business and will be held at the Burlington County Hospital in Mt. Holly at 4 p.m. The meetings in October, December, February and April will be scientific with guest speakers and refreshments as heretofore. These meetings will be held at the Moorestown Field Club at 9 p.m., Moorestown, N. J.

The result of the questionnaires sent to the members of this Society this summer relative to the subject of giving a percentage of the revenue received from the patients of the physicians who are in the military service back to these physicians was a preponderance of votes against the proposition.

Since several of the members who held posts as officers or were on committees have joined the armed forces, the nominating committee suggested the following to fill the vacancies:

CLINTON D. MENDENHALL, Treasurer

CHARLES A. MUNRO, H. P. SHIPPS—Program Committee

HOWARD HORNBERGER, Censor

These men were duly seconded and approved by the Society.

From the floor E. J. HAINES was nominated for the Nominating Committee and was seconded and approved by the members.

The Tuberculosis League is x-raying the chests of industrial workers of Burlington County on a purely voluntary basis. Employees of several factories have availed themselves of this opportunity. Of the several factories already completed 90 per cent of the employees were x-rayed. Burlington County is the first county of New Jersey to do this work. Other counties are now following this plan. This work is sponsored by the Public Health Service.

DR. NORMAN SCOTT of the State Society was present and discussed several questions which concerned the Procurement and Assignment Bureau.

The following members of the Burlington County Medical Society are in the armed forces:

R. D. ANDERSON	D. H. LE FAVOR
R. W. BETTS	F. W. METZER
E. V. DAVIS	E. A. MEYER
R. E. HALDEMAN	E. J. MULDOON
H. M. HEBBLE	J. NEWMAYER
C. P. HOGAN	A. B. SAND
E. R. IMHOFF	P. R. SPARKS
J. M. KUDER	A. V. ZICCARDI
H. P. LANDIS	

## GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The regular meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club with the new President, Dr. CECIL SHEETS, presiding.

DR. JOHN A. KOLMER, Professor of Medicine at Temple University, gave a very interesting talk on "The Sulfonamide Compound in the Prophylaxis and Treatment of Disease". He stated that prontosil is frequently most beneficial in the treatment of hemolytic streptococcal infections where sulfanilamide usually fails. Apparently there is some additional factor in prontosil which has not as yet been discovered. Sulfapyridine is most fatal to the kidneys and the urine must be watched constantly. Sulfathiazole is one of the best compounds of the group and is most beneficial in staphylococcal. All sulfonamide compounds are not equally effective on the same organisms, therefore it is important to determine the type of bacteria present especially in meningitis and pneumonia.

Factors in Treatment: (1) Early treatment most important. (2) Toxicity is very low but drug should be given until the diagnosis is made. (3) Always make the first dose large so that the bacteria are overcome as soon as possible. (4) Make blood con-



centrations whenever possible. (5) Intervals between doses should be every four hours, day and night.

He suggested as a prophylaxis in common colds that the sulfonamide compounds should be given for at least five days in order to reduce the possibility of a secondary infection. It can also be used in scarlet fever and measles for the same reason.

### HUDSON COUNTY

Harold Gorenberg, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, May 5, 1942, at the Masonic Club. The President, Dr. A. J. CONTY, presided.

In the scientific session Dr. HERBERT F. TRAUT, Associate Professor of Obstetrics and Gynecology, Cornell University Medical School, presented the subject "The Early Diagnosis of Carcinoma of the Uterus", which was afterwards discussed by Drs. Waters, Norton, Alter, Londrigan, and terminated by Dr. Traut. Dr. A. J. Conty, on behalf of the Hudson County Medical Society, thanked Dr. Traut for his very interesting and timely presentation of the subject.

The Medical Preparedness Committee reported having been kept constantly in touch with many phases of the medical preparedness program, and Dr. Cosgrove, the chairman of the committee, has continued to cooperate with the State Selective Service authorities in nominating and recommending members for the medical staffs of various local draft boards, appeal boards and induction boards. Up to this time the demands of this service have been successfully met. The whole Society and citizenry owe a debt of gratitude to those members of our Society who have so unselfishly given their time and effort, often under extremely uncomfortable conditions, to supply personnel to our armed forces.

The Society adopted at this Annual Meeting a formal resolution of appreciation to these men.

Your committee has also cooperated closely with the Defense Councils and their medical representatives in all communities of the county and in all hospitals of the county. The chiefs of the various Emergency Medical Services have been most cooperative and have shown commendable interest, intelligence and assiduity in devising and perfecting their emergency medical set-ups in accordance with the particular needs of their several community situations. The hospital authorities without exception have expended money and effort freely in organizing their staffs and equipping their buildings to render the facilities of these several hospitals effective in meeting the potential problems impelled upon them by the war.

In the several experimental black-outs and in the mobilization of personnel that have been from time to time carried out, the hospital organizations have met the test in splendid fashion.

This is a progress report and nothing is final in the arrangements so far made. Changing conditions in the military situation and as a result of our increased experience in both experimental and actual episodes, changes, perhaps fundamental, will

be necessary from time to time in certain details of the arrangements so far set up.

### MEMBERSHIP COMMITTEE REPORT

Dr. V. P. BUTLER, Chairman of the Membership Committee, points with pardonable pride to the membership, now 490, which is the highest in the history of the Hudson County Medical Society, and gives full credit to the late Dr. William T. Callery who was for many years Chairman of the Membership Committee. The effect of his work is well shown in our present enrollment.

### REPORT OF DELEGATES

Dr. J. F. NORTON reported that there were only two matters of controversy presented at the Convention of The Medical Society of New Jersey, held April 21-23, 1942. Dr. Samuel Alexander was elected Second Vice-President, Dr. Joseph F. Londrigan First Vice-President, Dr. Elias J. Marsh became President, and Dr. Ralph Hollinshed was made President-Elect.

In conformity with the instructions issued to the Delegates of the Hudson County Medical Society against Annual Registration, several members of the Society appeared before the Reference Committee and spoke against it and several members also spoke before the House of Delegates. The proposal to adopt Annual Registration was defeated by the Delegates' vote.

The Medical Service Plan of New Jersey had been revised, and the two changes in this Plan were approved.

An increase in dues of \$1.00 was passed by the House of Delegates because of the increased financial burden of men called into service, whose dues were remitted or credited by the Delegates' order.

Dr. A. J. CONTY, in stepping out of office, said he enjoyed being presiding officer; and the splendid attendance at the meetings; the loyal cooperation of the various committees and the willing assistance of his fellow officers.

### ELECTION OF OFFICERS

The Secretary cast one ballot for the election of the full officers:

President, W. A. Pinkerton  
Vice-President, T. McG. Brennock  
Treasurer, A. J. Conty  
Secretary, V. P. Butler  
Reporter, H. Gorenberg

Dr. W. A. PINKERTON expressed his appreciation for the honor conferred upon him in his election as President and promised his best efforts.

### OCEAN COUNTY

Frederick N. Bunnell, M.D., Reporter

The *Ocean County Medical Society* met at the Royal Pines Hospital September 9, 1942.

On motion it was decided to suspend rules and regulations of the Constitution and By-Laws pertaining to the number of meetings (10) the Society shall have per year, and instead have them only at the call of the President, as one-half of our small membership is in the armed forces of the United States.

## BOOKS RECEIVED FOR REVIEW

**FIRST AID AND BANDAGING;** a handbook of first aid and bandaging by Arthur D. Belilios, M.B., B.S. (Lond.), D.P.H. (Eng.), and others. Baltimore, Wm. Wood, The Williams & Wilkins Company. 1942. \$1.75.

**WAR MEDICINE;** a symposium. Ed. by Winfield Scott Pugh, M.D.; Edward Podolsky, M.D., associate editor, and Dagobert D. Runes, Ph.D., technical editor. Pp. 565. New York, The Philosophical Library. 1942. \$7.50.

**CLINICAL ANESTHESIA;** a manual of clinical anesthesiology. By John S. Lundy, B.A., M.D. Pp. 771. Philadelphia, W. B. Saunders Company, 1942. \$9.00.

**FIRST AID, SURGICAL AND MEDICAL.** By Warren H. Cole, M.D., F.A.C.S., and Charles B. Puestow, B.S., M.S., M.D., Ph.D., F.A.C.S. Pp. 351. New York, D. Appleton-Century Company. 1942. \$3.00.

**TRAUMATIC SURGERY OF THE JAWS INCLUDING FIRST-AID TREATMENT.** By Kurt H. Thoma, D.M.D. Pp. 315. St. Louis, C. V. Mosby Company. 1942. \$6.00.

**PHARMACOPOEIA OF THE UNITED STATES OF AMERICA** (the United States Pharmacopoeia) 12th revision (U.S.P. XII). By authority of the United States Pharmacopoeial Convention meeting at Washington, D. C., May 14 and 15, 1940. Prepared by the Committee of Revision and published by the Board of Trustees. Official from November 1, 1942. Pp. 880. Easton, Pa. Mack Printing Company. 1942.

**EMERGENCY CARE.** By Marie A. Wooders, B.S., R.N., and Donald A. Curtis, M.D. Pp. 560. Philadelphia, F. A. Davis Company. 1942.

**TEXTBOOK OF GYNECOLOGY.** By Arthur Hale Curtis, M.D. 4th ed. Pp. 723. Philadelphia, W. B. Saunders Company. 1942. \$8.00.

**THE HAND;** its disabilities and diseases. By Condict W. Cutler, Jr., M.D., F.A.C.S. Pp. 572. Philadelphia, W. B. Saunders Company. 1942. \$7.50.

**CENTRAL AUTONOMIC REGULATIONS IN HEALTH AND DISEASE,** with special reference to the hypothalamus. By Heymen R. Miller, M.D., introduction by John F. Fulton, M.D. Pp. 430. New York, Grune & Stratton. 1942. \$5.50.

**FIRST AID TO THE INJURED AND SICK;** an advanced ambulance handbook. Ed. by Norman Hammer, M.R.C.S. 18th ed. Pp. 336. Baltimore, Williams & Wilkins Company. 1941. \$2.00.

**SYNOPSIS OF PATHOLOGY.** By W. A. D. Anderson, M.A., M.D. Pp. 661. St. Louis, C. V. Mosby Company. 1942. \$6.00.

**WAR AND THE DOCTOR;** essays on the immediate treatment of war wounds. Ed. by J. M. MacKintosh, M.D., Chief Medical Officer of Department of Health for Scotland. Pp. 135. Baltimore, Wm. Wood, The Williams & Wilkins Company. 1941. \$2.00.

## BOOK REVIEWS

**Nutritional Deficiencies; Diagnosis and Treatment.**

By John B. Youmans, A.B., M.S., M.D., assisted by E. White Patton, M.D. Pp. 385. Philadelphia, The J. B. Lippincott Company. 1941. \$5.00.

This book represents a dignified approach to a subject that is currently engaging the attention of the government, the research worker and the manufacturer.

Because of the obvious importance of optimum good health in the war worker in and behind the battle line, the attention of the profession is directed to the importance of foods and accessory food substances.

The first part is an exhaustive description of each vitamin following the traditionally accepted form of history, nature and functions, incidence and epidemiology, symptoms and signs and diagnosis and treatment. Following the vitamins are chapters on other important substances in nutrition: proteins, iron, iodine, fats and trace elements.

A tabular summary of the vitamins and a list of the principal dietary sources of the essential food factors are useful parts of this book. For those interested in the minutiae of current laboratory methods that are useful for diagnosing deficiency diseases a large final section is available.

The few photographs are excellent but this reviewer would have liked to see more of these especially in color and demonstrating particularly subclinical avitaminotic states. The description of mild subclinical deficiencies is particularly timely during this war period.

Of course the unfortunate feature of a book dealing with such a rapidly changing and dynamic subject matter is that it becomes out-of-date even before it is published. The additions and changes that have occurred in the components of vitamin B complex since this book has been published are an example.

Such a confusing array of vitamins with new letters has been discovered within the past few years that this reviewer hopes that one with the letter Z will soon be discovered and so settle this matter for all.

This excellent book is recommended to the clinician, the military physician and the clinical pathologist.

BENJAMIN SASLOW.

**Diseases of Metabolism:** Detailed Methods of Diagnosis and Treatment. A text for the practitioner. Ed. by Garfield G. Duncan, M.D. Pp. 985. Philadelphia, W. B. Saunders Company. 1942. \$12.00.

The editor states the aim of this book in the introductory remark of his preface: "It is to provide for the physician a practical basis for the understanding, diagnosis and treatment of the various metabolic disorders."

Those who have observed the development of medicine in the last few decades will remember how young the science of metabolism is as a separate entity and what rapid progress has been made in recent years. The book under review is an eloquent



proof of the highly successful development of our knowledge in this field and is a concise compilation of normal and abnormal metabolism for the general practitioner. The known facts are briefly enumerated, current theories are restricted to a minimum and the usual extensive bibliography has been wisely omitted.

About one-third of the text is devoted to the physiology of metabolism. Normal and pathological states are skillfully contrasted. Carbohydrate, protein, lipid, water and mineral metabolism are first discussed. In a concise but comprehensive article our present-day knowledge of the vitamins in health and diseases is presented. Then the diseases of metabolism proper are dealt with; undernutrition, obesity, lipoidoses, glycogen disease, disturbances of intermediary metabolism, gout, hyperinsulinism, diabetes insipidus, the melliturias and diabetes mellitus, each in a separate chapter. Although clinical considerations are stressed as being of primary importance, due consideration is given to laboratory data as aids in diagnosis and treatment.

The authors are fully aware of the difficulties of limiting themselves to the original task without invading allied fields, as those of nutrition, endocrinology and other branches of internal medicine. An added brief chapter on the nutritional and metabolic aspects of the blood dyscrasias is interesting. With our present knowledge, metabolic disorders and internal medicine are thoroughly interlocked and are inseparable, as this book shows. A physician choosing internal medicine as his life's work must be thoroughly familiar with metabolism; and one treating diseases of metabolism should have a detailed knowledge of every branch of internal medicine.

G. G. Duncan, the editor and one of the chief contributors to this volume, has chosen a group of outstanding authorities on internal medicine and biochemistry to write the various chapters. Among these are W. Bauer, H. R. Butt, A. Cantarow, N. H. Long and J. P. Peters. The late Sir Frederick Banting a few days before his untimely death wrote the foreword, wishing the book the success that it so justly deserves. I feel certain that there is no physician who could not find worthwhile information in this excellent treatise, no matter in what branch of medicine he may be interested.

WILLIAM NYIRI, M.D.

**Electrotherapy and Light Therapy**, with the essentials of hydrotherapy and mechanotherapy. By Richard Kovacs, M.D. 4th ed. Pp. 735. Philadelphia, Lea & Febiger. 1942. \$8.00.

"Electrotherapy and Light Therapy" by Dr. Richard Kovacs has become a well-known reference book in this field. His new fourth edition has been enlarged considerably with new chapters on hydrotherapy, exercise and massage. These chapters furnish the general practitioners with the essential information needed about the therapeutic use of these measures and should prove of value. The other parts of the book deal with electrophysics, general electrotherapy and electrodiagnosis and light therapy, and applied physical therapy. This last part is exhaustive and full of practical infor-

mation about the use of physical therapeutic measures in such varying conditions as cardio-vascular, respiratory, gastro-intestinal, metabolic, chronic arthritis and fibrositis, affections of the central nervous system, affections of bones, joints, muscles and tendons, gynecological, genito-urinary, proctological, dermatological conditions and diseases of the eye. There are also excellent chapters on physical therapy in office practice and in institutional practice.

The book can be highly recommended to physicians as one of the best.

B. S. TROEDSSON, M.D.

**Nephritis**. By Leopold Lichtwitz, M.D. Pp. 328. New York, Grune & Stratton. 1942. \$5.50.

A refreshingly new approach to a subject in which there has been very little revealed since the time that Bright first described it, is presented in this book. A chapter on the clinical physiology of the kidney and another on water metabolism are particularly interesting. Like the rest of the text, however, they are not easily read but must be studied and digested. This is in no derogatory sense, but rather indicates the new type approach to the subject matter. The text is distinctive for the use of a large amount of basic work by the author himself and leads to some practical suggestions for the simpler study of various kidney conditions.

As might be suspected, the hypothalamic angles of water metabolism are given careful consideration. The chapter on the kidney in pregnancy adds nothing new to the general picture. This is primarily a book for the specialist in internal medicine.

EVERETT O. BAUMAN, M.D.

**The Modern Attack on Tuberculosis**. By Henry D. Chadwick, M.D., and Alton S. Pope, M.D. Pp. 96. New York, Commonwealth Fund. 1942. \$1.00.

An inspiration and a challenge to those particularly interested in tuberculosis control are contained in this short presentation on "The Modern Attack on Tuberculosis". The book includes facts and observations on the reduction and current prevalence of tuberculosis, advances made in means and methods of prevention and control, and problems in applying these advances in an effective manner. It is of greater interest to those especially concerned in the administration and application of control measures than to those interested in the disease only from the pathological or clinical point of view.

The epidemiological aspects in control measures are stressed and the importance of viewing tuberculosis as a communicable disease. Unwillingness to look upon tuberculosis as a communicable disease is advanced as a factor which has unquestionably retarded control.

Early recognition of cases is emphasized as an increasingly important first step in breaking the chain of infection from person to person. Diagnostic procedures are discussed; physical examinations, sputum studies and tuberculin tests are considered as supplying evidence supplementary to the x-ray.



The authors conclude that the x-ray will demonstrate an infiltration in the lungs long before signs of the disease can be otherwise detected and that an examination for pulmonary tuberculosis should not be considered adequate, unless it includes a roentgenogram of the chest.

Increase in the number and utilization of beds in sanatoria for tuberculous patients is considered an important factor in the reduction both of deaths and new cases of the disease. The sanatorium affords a place for treatment, a place where the patient learns the necessity of keeping within the limits of the safety zone and to stop the spread of infection to members of the family and to the public.

Tuberculosis, according to the authors, presents one of the hardest administrative problems that confront the health officer, but they urge that full use be made of the knowledge now available, and prophesy that, if there were put into practice the knowledge we have of epidemiology and treatment, tuberculosis could be reduced to a minor public health problem in one generation. Grave fear is expressed, however, that a high proportion of cases admitted to hospitals will continue to be in the far advanced stage, unless we make roentgen examinations of supposedly well persons a community procedure. They urge that greater emphasis be placed on the examination of family contacts including adults and on the mass examination of groups subject to the highest risks, such as workers in hazardous industries and adults on relief rolls.

Anyone interested in tuberculosis, either from the standpoint of the family physician, the specialist in this field, or the Public Health worker will profit by reading this presentation.

WILLIAM H. MACDONALD.

**Collected Papers of the Mayo Clinic and the Mayo Foundation.** Ed. by Richard M. Hewitt, B.A., M.A., M.D.; A. B. Nevling, M.D.; John R. Miner, B.A., Sc.D.; James R. Eckman, B.A., and M. Katharine Smith, B.A. v. 33. Philadelphia, W. B. Saunders Co. 1942. \$11.50.

Volume thirty-three of the Collected Papers of the Mayo Clinic and the Mayo Foundation is as welcome to the medical profession as its many predecessors. It contains certain sections of particular interest.

The volume appropriately commences with a subject foremost in our minds today—aviation medicine. The participation of the Mayo Clinic and Foundation in the rapid advances made in this field has been noteworthy. This entire section should be read by every practitioner.

The papers on anesthesia and gas therapy are of special interest, particularly those dealing with regional anesthesia. The remaining papers of the book cover articles on a variety of subjects, ranging through almost the entire field of medicine.

Every practitioner, regardless of his special interests, should find something of value in this splendid volume.

C. ABBOTT BELING.

**Blood Grouping Technic: A Manual for Clinicians, Serologists, Anthropologists, and Students of Legal and Military Medicine.** By Fritz Schiff, M.D., and William C. Boyd, Ph.D.; with a foreword by Karl Landsteiner. Pp. 248. New York, Interscience Press, Inc. 1942. \$5.00.

This is a most unusual book and one which should take a prominent place in the libraries of all blood laboratories. It is unusual from the standpoint of being concise and to the point in describing methods and interpretations. The treatment is quite different from that in many books on the subject and this is probably an attempt by the present author to transpose the original mood of the book into the English language. In the first chapter, "Theoretical Foundations", this has been carried to the point that it reads like a verbatim translation from the German. Other chapters are more to our taste.

The methods outlined are simple, concisely detailed and illustrated. There is a complete "Special Application" chapter covering the many applications of typing and serological absorption techniques. Forensic aspects are carefully set down, with an honest definition of what a blood-grouping expert really should be.

The section on anthropological grouping is very complete and the studies show careful investigation. There are only rare typographical errors and on the whole the book is well put together. Its size is attractive. Above all, the able presentation of the material must be praised.

MURRAY W. SHULMAN.

**War Gases: Their Identification and Decontamination.** Morris B. Jacobs, Ph.D. Formerly Lt. U. S. Chemical Warfare Service Reserve. Cloth, 180 pp., 6 illustrations, \$3.00. Interscience Publishers, Inc., New York.

This is a timely book written for the purpose of presenting under one cover a comprehensive survey of the practical aspects of chemical warfare, particularly as concerned with civilian defense.

The material presented has been compiled from recent publications on the subject and will serve as a ready reference for the newly formed casualty section attached to the Emergency Medical Service of Civilian Defense organizations.

Oddly enough, though the book is directed principally to civilian defense personnel, the subject of personal decontamination is not discussed. Decontamination of material and food and water is fully covered. There is a comprehensive section on the identification of chemical warfare agents by laboratory and field tests which are described in detail. All in all, this is a good reference book for the health officer, decontamination officer, gas identification officer, war gas chemist and, indeed, civilian defense personnel in general, containing not only all they should know, but even more than their needs require.

R. A. KILDUFFE, M.D.

# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

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No. 10

TO meet the menace of a rise in the tuberculosis death rate due to war conditions, a renewed emphasis must be laid upon special problems in the fight to control and ultimately eradicate the disease. It is timely and pertinent to call attention to certain of these problems where assistance of the general medical profession is indispensable.

Industrial problems and racial problems stand out clearly against the background of our national health which is threatened by the exigencies of war. The following cogent article is illustrative of the situation existing in various parts of this country, one which can only be met by concerted action on the part of the medical profession. The Weld County, Colorado, problem may differ in extent but not in kind from countless similar ones which confront physicians the country over.

### **PULMONARY TUBERCULOSIS AMONG SPANISH-SPEAKING PEOPLE**

It is a well established fact that the incidence of pulmonary tuberculosis varies markedly in different races. Roughly, there appears to be an increase in incidence as the pigmentation of the skin characteristic of the race increases, and also increasing with the magnitude of climate change occurring when the darker skinned races migrate to colder regions. Thus, a native of the tropics coming to Colorado to live is more liable to contract tuberculosis than is a native Coloradoan. Whereas the present death rate for tuberculosis in the United States Registration area is approximately 36 (in 1940) per 100,000 population in whites, the rate for Negroes is almost three and one-half times that number.

The incidence of tuberculosis in the Mexican falls between the rates for Negroes and whites. However, reported figures have shown fairly wide variations. These variations are to be expected, inasmuch as the Mexican who was born and raised in the Rio Grande valley and who later moves across the river into the Texas side of the valley has made no change in climate at all, but the Mexican who migrates from Monterey to Colorado has made a very decided change. It is therefore expected that the incidence of tuberculosis among Mexicans coming to Colorado will be greater than that among those stopping in southern Texas, New Mexico and Arizona.

The Weld County study, under the joint sponsorship of the Weld County Tuberculosis and

Health Association and the Weld County Health Department and Public Health Laboratories, shows the tuberculosis problem which exists among the several thousand Mexicans residing in this Colorado county. Nearly all of them are occupied in farm work, mainly the planting and harvesting of sugar beets. Over half of them live in "Spanish Colonies." Living conditions are quite uniformly sub-standard and crowded. This undoubtedly contributes in no small measure to the picture presented by this study.

During the thirty-month period September 1, 1939, to March 1, 1942, a case-finding program was carefully conducted among the Mexican population of Weld County. A total of 1,745 persons were tuberculin tested and all positive reactions followed up with an X-ray. Of the reported such studies, very few have contained complete follow-ups of all positive reactors. The Weld County study is now complete except for the progress following diagnosis and treatment of all active cases found.

The tests were made, for the most part, in "Spanish Colonies" after showing a series of educational films produced by the National Tuberculosis Association. The interest response was very gratifying and all age groups attended, as is shown in the figures of Table I. The ages ranged from less than two years to over 70.

The remainder of the persons included in the study were segregated from the testing programs

carried on in the schools of the county, and a few persons who were tested for various reasons. On the whole, the group studied should represent a very nearly accurate cross section of the Mexican population of the county.

The results of the study are diagrammatically shown in Table I. Of the 1,745 tuberculin tested, 745, or 42.7%, had positive reactions. These 745, along with forty other persons from families in which active tuberculosis was found, were given chest X-rays. These forty people had not had previous tests.

TABLE I

Total Tuberculin Tests .....	1,745
Under 16 years .....	986
Over 16 years .....	759
Negative Reactions .....	1,000
Under 16 years .....	702
Over 16 years .....	298
Positive Reactions .....	745
Under 16 years .....	284
Over 16 years .....	461
All 745 reactors given chest X-rays	
Known Contacts .....	40
40 members of families with active tuberculosis also X-rayed; total of 785 chest X-rays	
Chest Films with Negative Findings .....	481
Referred to Chest Clinic for further study .....	304
Active Tuberculosis Cases Discovered .....	61
Sanatorium recommended .....	47 cases
Pneumothorax clinic and home care .....	3 cases
Hospitalized by Las Animas County .....	1 case
Died in Island Grove Hospital pending sanatorium care ....	10 cases
Admitted to sanatorium .....	42 cases
Refused sanatorium treatment	2 cases
Left the county .....	2 cases

In 481 of the chest X-rays, there was no evidence of tuberculous activity and they were dismissed from further study.

In 304 cases radiographic evidence ranged from merely suggestive to definite evidence of pathology. These were referred to the Chest Clinic of the County Health Department for further study, including physical examination, sputum examinations and cultures. Sixty-one were found to have active pulmonary tuberculosis. The disease status of the active cases is shown in Table II.

TABLE II

Disease Status of the 61 Active Cases	
Far Advanced .....	51
Recommended to sanatorium care .....	41
Died in Island Grove Hospital .....	10
Moderately Advanced .....	4
Recommended to sanatorium care .....	1
Pneumothorax and home care .....	3
Minimal .....	4
Followed in Chest Clinic	
Refused to coöperate so that accurate evaluation of their disease status is impossible, probably moderately advanced .....	2

#### Summary and Conclusion

Of 1,745 tuberculin tests given, 745 positive reactions, or 42.7%, were found. These were given chest X-rays, as were also 40 others from families in which active tuberculosis was found. Of the grand total of 1,785 cases, 304, or 17%, were at least suggestive of tuberculous pathology, as shown on the X-rays. Further study revealed 61 cases, or 3.42%, active tuberculosis.

Based on this study, the incidence of tuberculosis among the Mexican population of Weld County is found to be the staggering total of 34.17 per 1,000 population.

*Pulmonary Tuberculosis Among the Mexican Population of Weld County, Colorado, William J. Wilson, M.D., Rocky Mountain Medical Journal, June, 1942.*

SUPPLIED BY

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These results suggest that Phosphaljel is indicated in those cases of peptic ulcer associated with a relative or absolute deficiency of pancreatic juice, diarrhea or a low phosphorus diet.

The suggested dosage of Phosphaljel is one, or occasionally, two tablespoonfuls every two hours during the active stage of the ulcer. Later in the course of management, three tablespoonfuls with meals and at bedtime or two tablespoonfuls six times daily with or between meals is recommended. Wyeth's Aluminum Phosphate Gel is supplied in twelve fluid ounce bottles and is available at all pharmacies.

<sup>†</sup>Phosphaljel is accepted for use in the treatment of peptic ulcer associated with a relative or absolute deficiency of pancreatic juice, diarrhea or a low phosphorus diet.



Phosphaljel contains 4% aluminum phosphate and possesses antacid, astringent and demulcent properties analogous to those of aluminum hydroxide gel.

<sup>‡</sup>Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: *Aluminum Phosphate in the Therapy of Peptic Ulcer*, *Arch. Int. Med.* 67: 563-578 (March) 1941.

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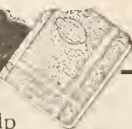
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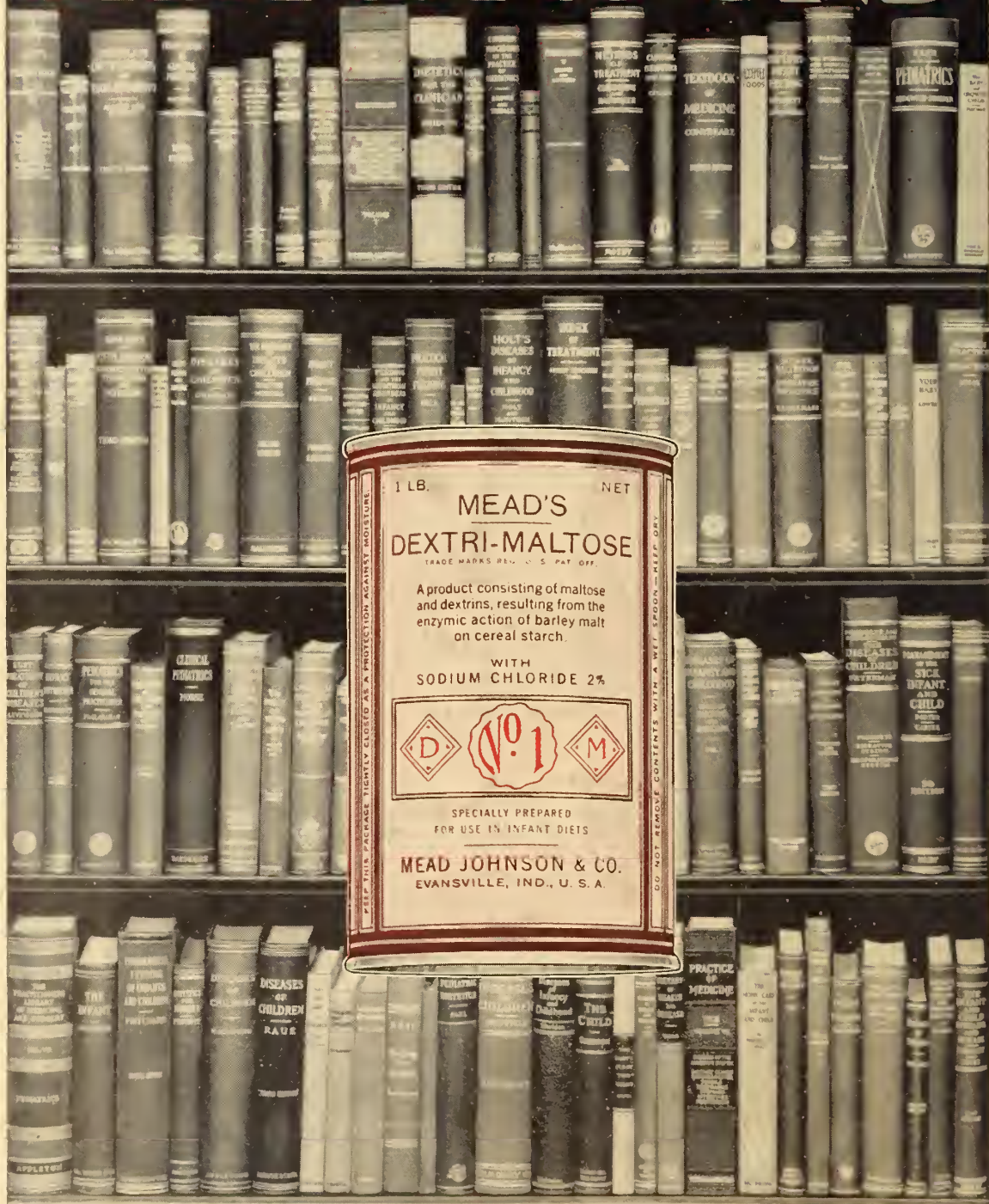
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### CONTENTS—Pages 567-614

#### EDITORIALS—

	Page
CAUSE AND EFFECT	567
WAR EFFORT OR REFORM	568
CONSTRUCTIVE CRITICISM	568
A LOOK TO THE FUTURE	568
LESSONS FROM SCHICKLEGRUBER	569
YOUNG MEN ARE IN DEMAND	570
PHYSICIAN HAVE THYSELF EXAMINED	570

#### THE WAR—

Answers to Certain Important Questions	571
Osteopaths	571
Taking Care of Children	572
Office of War Information	572
In Defense of Life and Liberty	573
Rehabilitation of Rejected Selectees	574
Colonel Seeley Transferred	574

#### ORIGINAL ARTICLES—

THE CORRELATION OF ROENTGEN RAY DIAGNOSIS OF LESIONS OF THE STOMACH AND DUODENUM WITH THE OPERATIVE FINDINGS WITH SELECTED CASE REPORTS—W. James Marquis, M.D., and C. F. Baker, M.D., Newark	575
NEUROSYPHILIS IN RELATION TO OPHTHALMOLOGY—Irvin Levy, M.D., Trenton, N. J.	581
THE EFFECT OF AMPHETAMINE (BENZEDRINE) SULPHATE, PROPADRINE HYDROCHLORIDE AND PROPADRINE HYDROCHLORIDE IN COMBINATION WITH SODIUM DELVINAL ON THE APPETITE OF OBESE PATIENTS—S. William Kalb, M.D., Newark, N. J.	584
A LESSON FROM A DEATH CERTIFICATE	586
OVARIAN TUMORS COMPLICATING PREGNANCY. Maternal Welfare Article No. 75—R. A. MacKenzie, M.D., F.A.C.S., Asbury Park, N. J.	587

EXECUTIVE OFFICER'S PAGE	590
--------------------------	-----

#### LEGISLATIVE NEWS—

Social Security Act Amendments of 1942	591
Vocational Rehabilitation	593
Medical and Hospitalization Benefits for Veterans of World War II	594

#### TIMELY TOPICS—

Heating and Health	595
Facts Concerning the Work of the Municipal Aid Administration	596
Children's Feet	596
Post-Graduate Industrial Medicine	597

#### STATE ACTIVITIES—

Change of Address	598
Supreme Court to Review Questions Related to Practice of Medicine	598
Medical Care for Wives and Children of Enlisted Men	599
With New Jersey Medical Authors	601
Members Serving in the Armed Forces	601
Supplementary List of Members	603
Deceased Physicians	603

BULLETIN BOARD	604
----------------	-----

#### COUNTY SOCIETY REPORTS—

County Society Reporters	605
Burlington and Morris Counties	606
Passaic County and Summit Medical Society	607

#### WOMAN'S AUXILIARY—

Coming Events	608
Stronger Not Weaker	608
State Board Meeting	609
Program	609
Essex County Auxiliary	610
Contributions by Auxiliaries	610

THE BOOK SHELF	611
----------------	-----

TUBERCULOSIS ABSTRACTS	613
------------------------	-----

Roster of Officers, Advertising Page 3A

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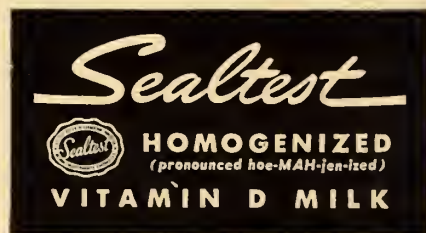
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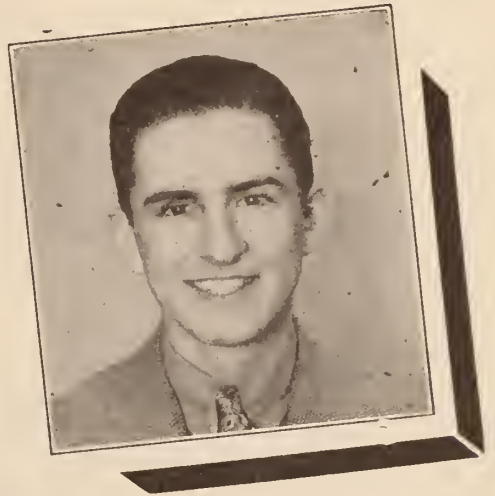
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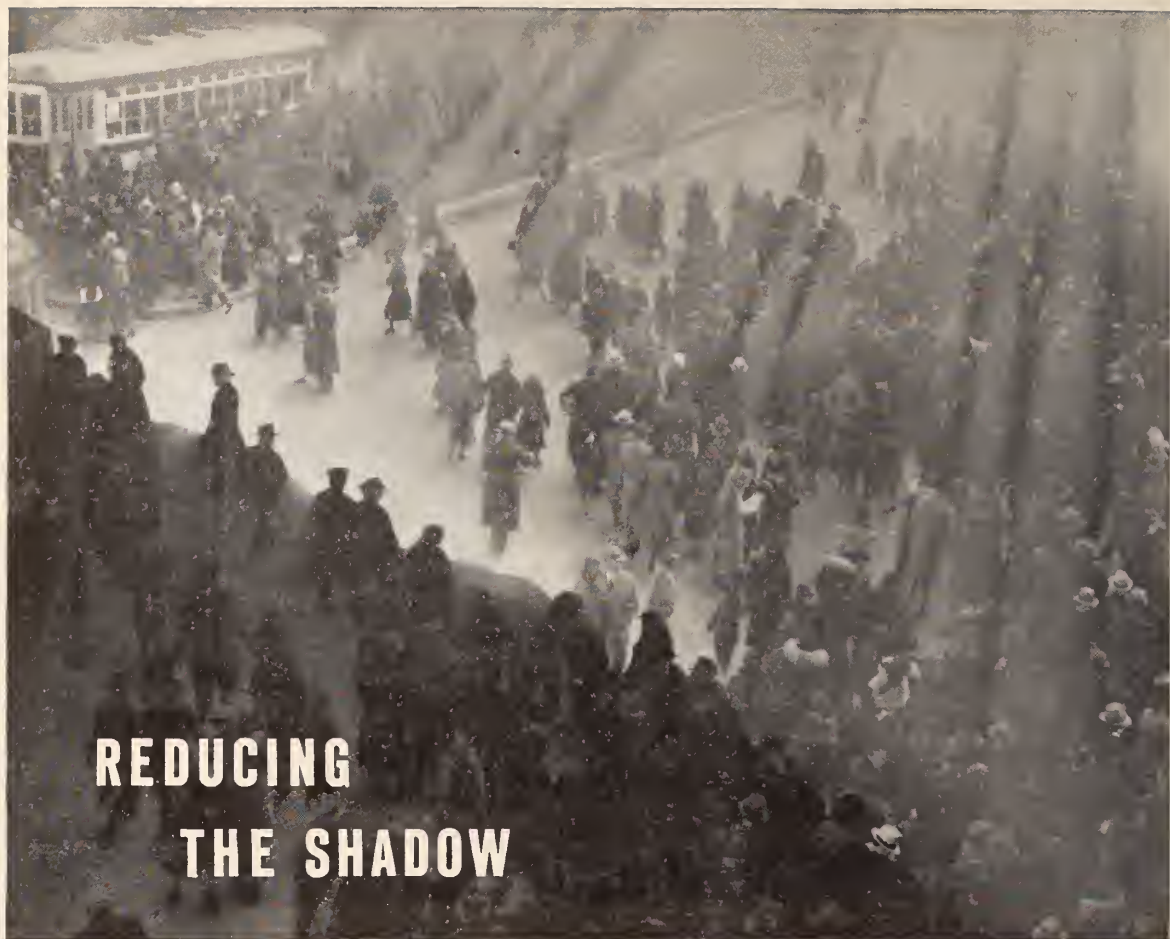
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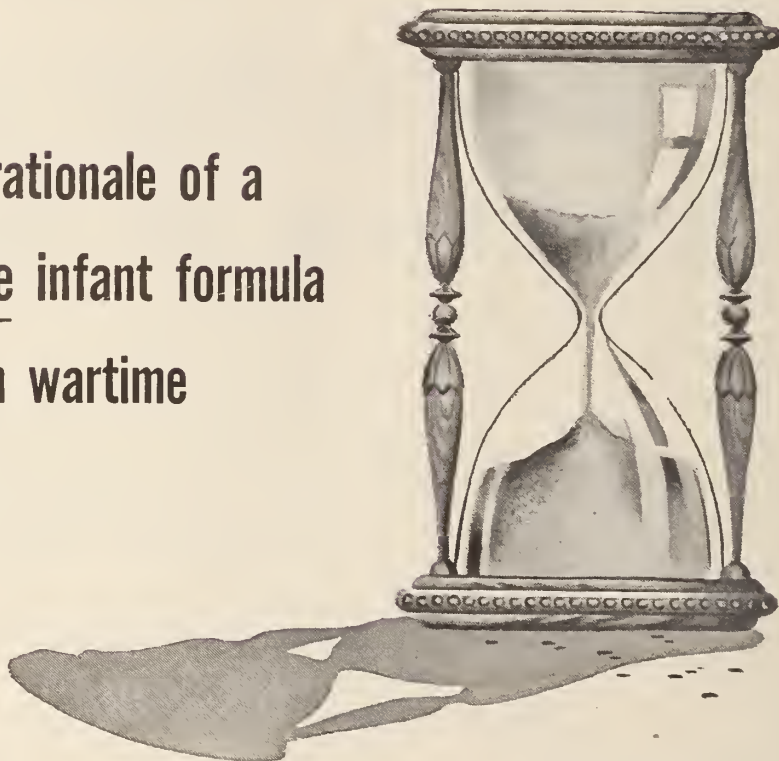


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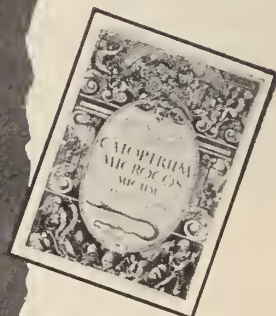
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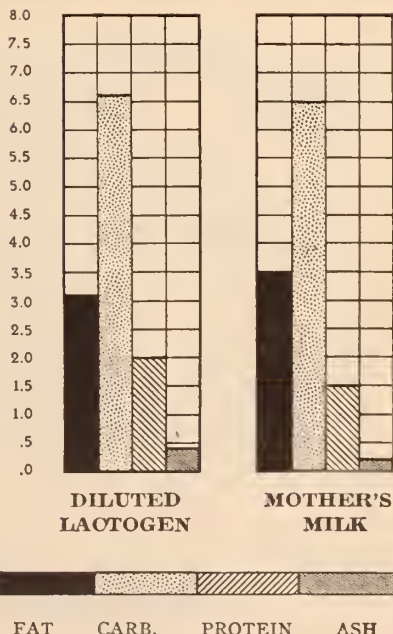
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John Lovett Morse, A.M., M.D.  
Clinical Pediatrics, p. 156.



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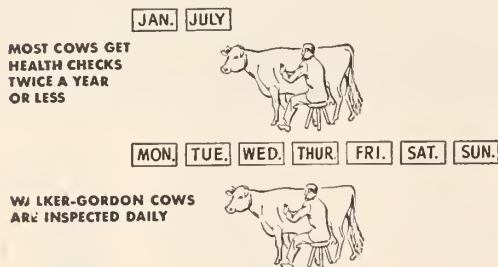


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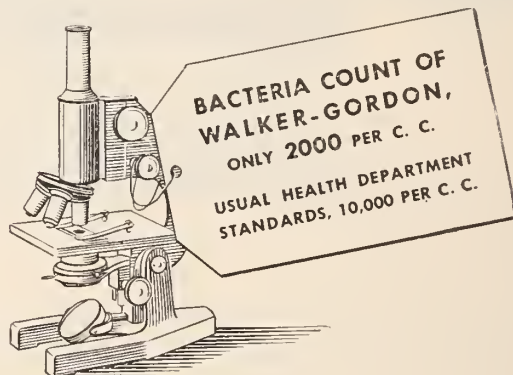
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\* Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154  
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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\*\*Interne: Sept. 1941

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\* *The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941  
*J. A. M. A.*, 93:1110—October 12, 1929  
*Brückner, H.*—*Die Biochemie des Tabaks*, 1936

★ ★

"THE CIGARETTE, THE SOLDIER, AND THE PHYSICIAN," *The Military Surgeon*, July, 1941. Reprint available. Write Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.



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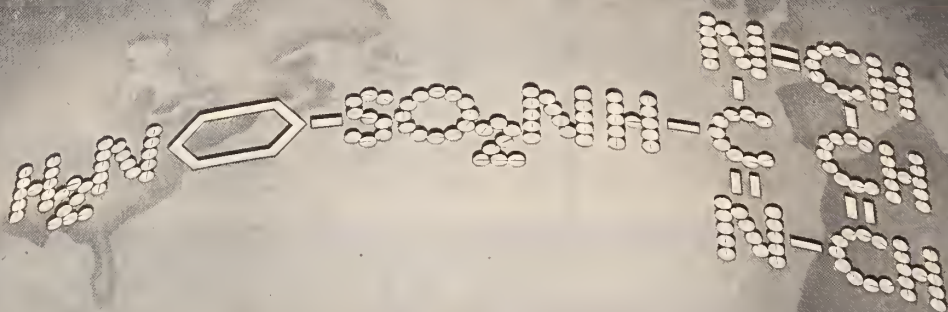
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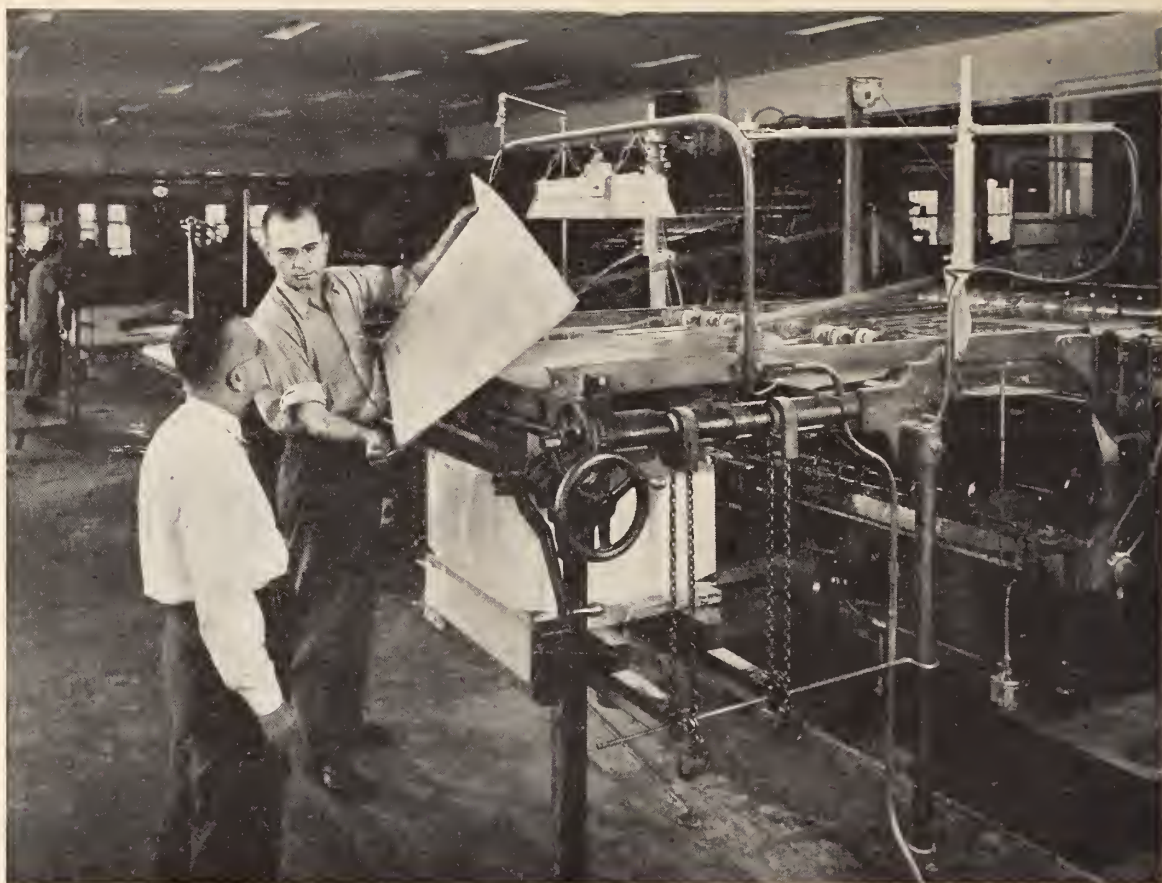


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# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

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UNDER THE  
DIRECTION OF THE  
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor  
IN ACTIVE SERVICE A. U. S.

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

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NOVEMBER, 1942

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## CAUSE AND EFFECT

The most absorbing topic of the day is undoubtedly the war. The most interesting aspect of this subject to *any* person is the effect which the war is likely to have upon *him* individually, and on *his* profession, trade or business.

The first effect upon the medical profession has been to emphasize its usefulness and to increase the public's demand for the services of physicians. They are demanded both by the Armed Forces and by the civilians remaining at home. The very essence of medical service lies in the humanitarian aim and effort of the members of the profession. Whenever and wherever humanity is attacked by man or machine, beast or germ, you will find the physician protecting and defending the people.

What has been the first effect upon the physician himself? Well, he has been eagerly sought by government and even

by those who once spoke slightly of his ideal and practice. His services have been sought at home and abroad—and he has responded, often at great sacrifice, but this sacrifice is not a new experience to the physician. His is now a bigger job, and the newer group-service now transcends the more familiar individual need. The physician, of course, needs help in caring for this increased demand for service. He naturally prefers the well-trained nurse, but she too is in great demand. He can and does use the technicians, but their field of competence is very limited. He can and will use, insofar as he safely can, those who have had even some training and experience, and he will necessarily keep a close eye upon their efforts while doing his own job too. Yes, the physician has become a very important and useful man, and he is in great demand.



## WAR EFFORT OR REFORM

On page 591 is to be found an analysis made by the Legislative Bureau of the A. M. A., which clarifies some of the provisions of the 1942 Amendments to the Social Security Law H.R. 7534. Reform measures are currently being confused in the public mind with war provisions. Reform appropriations are sapping funds badly needed at this time for arms and ammunition. If we are to win this war and save lives which will other-

wise be sacrificed needlessly, we must concentrate.

It is not pertinent to discuss at this time the importance or desirability of reform measures except as they are *essential* to winning the war. Let us place first things first and concentrate our thoughts, our efforts and our funds on this prime purpose of winning the war until it is accomplished.

---

## CONSTRUCTIVE CRITICISM

The State Department of Health is being reviewed by a member of the United States Public Health Service at the invitation of Governor Edison. It is a healthy sign when the set-up and procedure of any governmental agency is reviewed at local request, especially when an authoritative and neutral investigator is chosen to make the survey and recommendations. Such an invitation need not be predicated upon charges of negligence or incompetence—more often such an invitation implies a real desire to learn how we may further improve our organization and services to the public. Too often are public servants criticized destructively by incompetent critics, but constructive criticism from competent personnel is always welcome and gener-

ally helpful. It is a satisfaction to learn how others view our strength and weaknesses so that we may correct the latter, and it is a very satisfactory experience when commended by such investigators.

Periodic surveys should be welcomed and be made by the best people we can find. There are probably other agencies than our Health Department who would welcome a survey intended to aid in improving the work wherever possible in New Jersey. We have many agencies in New Jersey which could in turn be helpful to other states as a result of the experience they have gained in the conduct of programs which have already merited and received widespread attention outside our own state.

---

## A LOOK TO THE FUTURE

It is the duty and privilege of every young physician to respond to the government's call to war. Even though some of our younger physicians will not qualify to serve with the Armed Forces and will have to remain behind for various reasons, they can join with their older colleagues in serving on the home front. These younger men should look to the future for to them especially comes an added responsibility, since by their word and action they will contribute to the

development of a public opinion out of which will grow the future form of living and conduct in our state and country. Whatever form this takes in peacetime, it will influence medical practice, because medical practice is but an integral part of our manner of service.

Should the experience of the majority of the people lead them to favor a return to the system of free enterprise, with more emphasis on *individualism* there will undoubtedly be a return to that form of

government after the war. Should, however, the experience of the majority cause them to doubt that the individual with greater natural gifts and opportunities will continue to be concerned with the general good, we shall likely have a return to a new form of "ism" or an adaptation of one of the many forms already existing in various parts of the world. In spite of trends that have brought us closer to the European forms of government, we daily see honor being paid to those *individuals* who have contributed so greatly to the public good. Many of these men and women actually had to fight the public in order to provide the benefits the public later enjoyed.

There have been other well-meaning persons who have honestly striven to provide the public with benefits but were

unsuccessful in winning public support, and have received public recognition and appreciation only after they had passed away. One can also point to certain "evangelists", who, though honest, were definitely in the wrong, but they could not be convinced of the fact. There have been other individuals who, while masquerading as benefactors, pursued their own selfish ends. If there are enough of any kind of individuals who do not work for the general good, there will be a return toward collectivism in government on the part of the general public.

Of one thing there can be no doubt—no nation can stand forever divided against itself. Medicine will follow the general trend of the times in either direction as inevitably as day follows night.

---

### LESSONS FROM SCHICKLEGRUBER

It has been said that nothing is either wholly good or bad. All plans have elements of both qualities. What, then, is worthy of emulation in such a regime as that of the Nazis? Well, there is evidence in their plans of clearly established aims and objectives, of careful planning, of exact schedules and careful dispatch. The results, though bad in our eyes, have been rather uniformly successful from the Nazi viewpoint. The atrociously bad elements in their plans finally increased the antagonism and resistance of decent peoples to the point where we forget all else.

We doctors can learn much about the use of plans and schedules from this war. We can apply this knowledge beneficially to further increase the distribution of our services and the cost thereof to our patients. Our number is now depleted at home and the demand for our service is greater than ever. We must better plan and schedule our work.

There is also the lesson of the effectiveness of bold, swift, systematized action,

begun at the most opportune time and carried to a successful conclusion. When the Nazis do not finish a job they begin, the fault lies, not with them, but with the increasingly superior power of the enemy. What an achievement it would be if their aims were uniformly good enough to win universal support instead of opposition.

Many professional groups, including physicians, frequently discuss problems at great length but are slow and uncertain in action. No one will accuse the Nazis of such weaknesses. We would all be thankful if in their case they were slower and weaker in action—and if we were faster and stronger at all times. Action usually comes in spurts and progress follows proper action. Action of the wrong kind may, of course, end in disaster. It is the direction of the action which is most important. Actions speak louder than words and they often reveal both our ability and our intent. Yes, we can learn something, even from Mr. Schicklegruber.

## YOUNG MEN ARE IN DEMAND

This is a young man's war. The peace to follow must be formulated after consultation with the young men who win it, and who will carry out its provisions.

In all organizations the importance of the young man is being increasingly recognized and his advice sought. This advice is now being given equal attention with that of his elders. Organized Medicine, too, needs wider participation by our younger men and it needs their advice in its councils. The conditions faced in medical practice now are materially different than heretofore because of the evolutionary changes which have taken place so rapidly in the last two decades. These changes are still going on and the end is not yet in sight. Younger men are naturally less handicapped by tradition and prejudices, are more daring in their actions and experimentation, and more receptive to new ideas in their thoughts. They are more in line with and are influenced by current trends and public demand, and should, therefore, have an equal voice in shaping the plans and policies under which they will carry on the future practice of medicine.

This thought should not prejudice the valuable contributions to be made out of the extended experience and successful practice of our tried and true leaders who have already contributed so greatly to the progress of medicine. There has been, however, a tendency to consider *age* as the equivalent of *experience*. Many of our younger men have acquired more experience in the last decade than some of us have been able to gather in double that length of time. We need the infusion of new blood periodically in *all* organizations, if only to relieve our overworked leaders of the burden they have borne uncomplainingly for so long a time.

We need the stimulus of new ideas and of courageous action. The young men, too, need the advantage of contact with the fine examples of high ideals and ethics found in the passing generation. This contact will stimulate all who participate in our Society's efforts, and the public generally will profit because it is in their interest that the profession is constantly seeking to improve itself and its service.

---

## PHYSICIAN HAVE THYSELF EXAMINED

The subject of this editorial was suggested by a colleague whose patriotism exceeded his stamina. He learned by experience what some of us who are past middle age should apply as a preventive measure, i.e., the value of having a careful physical examination made by a chosen colleague. In our ardent desire to do our full part in the war we can best serve by limiting our efforts to our physical capacity. To do this successfully we must *ourselves* be carefully examined and advised before we start.

Some of our members who are beyond the draft age are doing their bit by taking over work of younger colleagues who

have gone to war. This is a noble aim and effort and within reason can be successfully and safely carried on—but—physician know thyself and thine infirmities if they exist, ere thou enter upon thy task. We need all good men and true in these trying times, especially physicians, and the men who keep on the job longest and accomplish most in the long run, are those who do not sacrifice themselves prematurely and unnecessarily by assuming an unbearable load at the outset of a truly patriotic undertaking. That youthful resilience we once enjoyed is no longer present in some of us, and discretion at our age is the better part of valor.



## THE WAR

### ANSWERS TO CERTAIN IMPORTANT QUESTIONS

1. *Medical Students.* Recent information indicates that a relatively large percentage of medical students have failed to join the reserve services of the Army or the Navy. It is urged that every student who has not yet done so should apply *immediately* for a commission in the Army or Navy. This will enable medical students to continue their training through one year of internship before they are subject to Selective Service.

2. *Interns.* Army—Interns may not enlist in the Medical Administrative Corps Reserve since this group was organized solely for the purpose of enabling medical students to complete their training. If a student is not a member of the Medical Administrative Corps, he is subject to the jurisdiction of the Selective Service System and may be inducted before he can complete the one year of internship which is required for commission as First Lieutenant in the Medical Corps of the Army of the United States. Interns, whether or not they have been in the Medical Administrative Corps Reserve during their attendance at medical school, cannot apply for a commission in the Army Medical Corps until 60 days before the completion of their internship.

Navy—The Navy *will* commission interns as Lieutenants, Junior Grade, if they meet the requirements, and they will allow them to complete their internship. We recommend, therefore, that students who contemplate service in the Navy should apply for commissions as Ensigns HV (P) in the Navy while they are in Medical School.

3. *Faculty Members.* No physician under 45 years of age, who is physically fit for mili-

tary service, should be declared essential to a medical school faculty unless he devotes at least 25 per cent of his time throughout the entire year of medical school training, clinical as well as formal. Any exception to this policy must be justified by unusual circumstances.

4. *Alien Physicians.* The Army and the Navy are not in a position to accept enemy alien physicians as commissioned officers because of the citizenship law. Also many of these physicians do not meet other requirements such as license to practice, internship, or other professional qualifications.

It, therefore, seems inadvisable to recommend that these aliens go into the Army as privates with the expectation of receiving citizenship at the end of three months, for many may not receive it for some reason, and they may not be acceptable to the Medical Corps even though they are given citizenship.

Since there are many places in which these men can be of service in civilian life, it is recommended that efforts be made to place those who are not acceptable for service with the Army or the Navy as temporary employees in hospital positions, in critical areas where more physicians are needed, in special positions in medical schools, and in public health agencies, etc. In such positions they may be rated as essential and may thus be used in their professional capacity.

Until definite rulings are made concerning the admission of this group into the military services, these general policies should be followed.

PROCUREMENT AND ASSIGNMENT  
SERVICE.

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## OSTEOPATHS

### A STATEMENT TO STATE CHAIRMEN FOR PHYSICIANS FROM THE DIRECTING BOARD OF PROCUREMENT AND ASSIGNMENT SERVICE

Inasmuch as members of the osteopathic profession have petitioned Congress and various public officials seeking their aid in: (a) securing commissions in the medical departments of the armed forces, and (b) obtaining deferment in order to continue to practice in their respective communities, the War Manpower Commission has suggested that we make our position clear in these matters.

1. The Procurement and Assignment Service has no responsibility, under Executive

Order, for the allocation of groups other than physicians, dentists, and veterinarians.

2. The Army and the Navy have established definite standards for admission to the Medical Corps. These standards have been developed over a long period of time, and the War Manpower Commission has no authority to change them. Insofar as the recruitment of specialized personnel for the armed forces is concerned, the Procurement and Assignment

Service must meet the standards prescribed by the several armed services.

3. Selective Service has the authority to place any man under the age of 45 in military service. If the Army and Navy demand certain selected groups for commissioning, Selective Service may request these men to apply for commissions. If there were more than enough physicians to supply the needs of the armed forces and of civilian groups, Selective Service would have the right to induct the remainder under their jurisdiction as privates in the same way they would any other professional group in a similar hypothetical situation.

4. Selective Service has provided for the deferment of all individuals who are essential to the community or to the war effort. Selective Service Release No. 279, dated July 14, 1942, specifically includes osteopaths among those individuals who may be considered for occupational deferment because of being engaged in an essential activity in this grouping.

Therefore, if osteopaths have a responsibility for the welfare of a sufficiently large part of the civilian population in a community and are found to be "necessary men", as defined by Selective Service regulations, Selective Service may defer them. This release was sent to all State Chairmen on August 26, with our Form Letter No. 120.

5. It is the opinion of the Procurement and Assignment Service that osteopaths should be deferred if, in the judgment of Selective Service, the demand for their services by civilian communities is sufficient to justify such deferment.

6. If the problem of passing upon the availability of osteopaths arises, it should be suggested that Selective Service Boards consider them from the viewpoint of their essentiality in the community. *State Chairmen of the Procurement and Assignment Service should not themselves pass upon the availability of osteopaths.*

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## TAKING CARE OF THE CHILDREN

The care of children during the day so that mothers can work is usually considered a community responsibility. The Douglas Aircraft Company, however, has recently announced its intention of opening a Day-Nursery for the children of the 4,000 women employees of its Santa Monica, California, branch. On the staff

there will be a child psychologist, a professional nurse and a dietician. This company's plans are a step in providing a solution to a problem which has begun to assume serious proportions as figures indicate that during the past two months industry has been hiring women at the rate of two to every one man.

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## OFFICE OF WAR INFORMATION

### WAR MANPOWER COMMISSION

"The Directing Board of the Procurement and Assignment Service is pleased to announce that 95 per cent of the 1942 procurement objective of medical officers for the armed forces has already been met. Toward this total a number of states have supplied more than their share of physicians and only a few states are lagging behind in their quotas. It is from these states that the additional physicians needed during the current year should come.

"The recruitment of such a large number of physicians in a few months is a remarkable achievement and another demonstration of the traditional patriotism and unselfishness of the medical profession. In this achievement, and particularly in those of its members who are 'in service', the profession can justifiably take pride.

"The end, of course, is not yet. Increases in the armed forces will necessitate more medical officers and additional demands will be made upon the profession for medical services in critical war production areas. The Directing Board is convinced, however, that the physicians of this country will respond to future calls for service, whatever they may be, in the same splendid manner with which they have already volunteered for service with the armed forces."

(Signed) FRANK H. LAHEY, M.D.  
HAROLD S. DIEHL, M.D.  
HARVEY B. STONE, M.D.  
JAMES E. PAULLIN, M.D.  
C. WILLARD CAMALIER, D.D.S.,

of the Directing Board.

## IN DEFENSE OF LIFE AND LIBERTY

At a meeting at the Essex House in New York on October 28, 1942, before an audience of more than 200 people—doctors, nurses and other responsible heads in the civil defense program of New Jersey—Mr. Leonard Dreyfuss, Civilian Defense Director of New Jersey, was introduced by Dr. Charles H. Schlichter, Emergency Medical Officer in the civilian defense set-up for this State. Mr. Dreyfuss outlined briefly the organization involving over 500,000 civilians distributed throughout the various defense organizations of the State. He predicted that in America we would have need for civilian defense because the German people themselves, as a result of bombing by American-built planes, are now demanding that Germany open a second front and are designating America as their choice.

The many complications involved in the building of a civilian defense program were pointed out by Mr. Dreyfuss—such questions as the liability of the community for injuries to voluntary workers, the resulting child delinquency as women workers are increasingly demanded in war industries; the integration of the Red Cross efforts in the State program of civil defense involving food, clothing, shelter for children, canteen work, hospital aides and first aid training. He emphasized the enormity of the problems and predicted a long war and warned that the civilian must expect increasing hardships, and that fifteen civilians were required for each man in the Armed Forces. He hoped the time would eventually come when peace would return and we could dispense with a bureaucracy and regimentation which were only justified in the emergency period. The sincerity of Mr. Dreyfuss and his comprehensive vision of the problems involved in the discharge of the obligations fixed upon him was brought vividly to the realization of everyone in the audience.

Dr. Schlichter then introduced the second speaker, Col. George Baehr of New York, who began as Chief Emergency Medical Officer in New York, and whose brilliant accomplishments have added further responsibilities until he is now a definite part of the national emergency defense organization, and doing, in the words of Dr. Schlichter, "an admirable job". Dr. Baehr has just returned from a study of the organization and procedures connected with civilian defense in the British Isles. In this study he gathered data of great value to us in the development of our own plans here, for which we have had no precedent. The English have developed their civilian defense on the basis of practical experience. Dr. Baehr em-

phasized his belief in the certainty that we shall experience bombings, at least in our industrial and port areas. Our greatest danger lies in our unpreparedness. England's greatest destruction took place in those areas which felt secure because of their historical importance and freedom from industrial war work and did not adequately prepare. In Dr. Baehr's opinion, we must immediately and properly prepare.

Destructive as the blasts have been, *fire* is by all odds the greatest menace to the civilian population. So great is the hazard of fire that a national fire service with a central control had to be established in England because the only one of the intercommunity agreements for mutual aid which did not work out, was the fire protection, since each community feared to allow any of its firefighting apparatus and personnel to go to the aid of another community.

While the English system of protection of the civil population in wartime cannot be duplicated for many reasons in the United States, we can learn from this system a great deal which can be adapted to our own needs. In spite of all of the extensive first aid training which England provided for the protection of its home population at the scene of disaster, experience has shown that at the actual scene practically no work is done except that of *rescue*, because of the dirt and commotion and other factors which prevent any effort at what might be termed "first aid". The injuries to those who survived at all were comparatively less than in other types of disaster because the great majority of the serious cases died, and those who escaped at all escaped with relatively slight injuries and could be treated at casualty stations as ambulatory patients. All others, in order to have any chance of recovery, must be rushed directly to the hospitals where facilities are available to make treatment efforts offer any hope at all.

The real bombing raids come always at night and rescue must be affected in total darkness, complicating greatly the efforts of the rescuers. The rescue squad has been relied upon for such first aid work as is at all possible and they are thoroughly trained in real first aid measures. Superficial first aid courses, such as England first gave, resembling, as Dr. Baehr put it, the Boy Scout courses, were found totally without value and the rescue squad workers were given very comprehensive courses before they were allowed to attempt any first aid work.

After each bombing attack the first notification given is to the fire fighters, who send what is called an express party or a skeleton



crew, representing the various services, immediately to the site of the incident. This plan is to conserve the waning manpower available and determine the urgency of need of supplementing it at certain areas, because incidents can occur in several places at the same time.

Dr. Baehr emphasized the great importance of transportation facilities and said that it was essential that specially trained drivers with specially constructed vehicles be provided. The use of commercial vehicles has proven to be a failure due to the fact that they were not always available and the drivers were not always trained to the needs. For hospital evacuation large buses like our Greyhound buses were used and there were a great number of these and other types of conveyance for sitting and stretcher cases.

Dr. Baehr emphasized the absolute necessity for adequate training for each of the specialized workers and that for any person not adequately trained to attempt to carry out the function assigned is likely to result disastrously as was convincingly demonstrated in the experience in England where they now insist on specialized personnel.

Next to the fire fighting personnel, which comes first in importance, Dr. Baehr placed second the rescue emergency service. Each hospital in London has an outlying hospital in the suburbs or on the periphery of the city to which patients are evacuated as soon as able, and where such medical teaching as is possible is done in these hospitals. In England there are four beds in such outlying auxiliary hospitals to each one bed in the central hospital. In the United States the plans call for the exact reverse ratio.

Dr. Baehr reported that the British morale remained excellent, that their confidence has remained firm in ultimate victory and in their own ability, and that their accomplishments so far have justified and strengthened under the trying ordeals through which they have passed.

Strangely, the health conditions in the British Isles are very good and malnutrition is less in evidence than in peacetime. England is producing twice as much foodstuffs as ever before and together with the supplementary food shipped from this country the citizens are adequately fed. The food is concentrated and limited, but appears to be adequate for nutritional purposes.

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## REHABILITATION OF REJECTED SELECTEES

Directors of Welfare will be interested to learn that the Municipal Aid Administration and the New Jersey Rehabilitation Commission have devised a cooperative plan for the rehabilitation of men rejected by the Army Medical Corps because of physical disabilities. The Rehabilitation Commission will interview the men rejected and refer cases to the local Director of Welfare with diagnosis and recommendations. The Directors of Welfare will then arrange for treatment through the medium

of local facilities. Details are being worked out. Request for this service will be on a purely voluntary basis and expenses where necessary will be shared between the State and the individual. There will be no financial burden other than administrative costs on the municipality. Directors of Welfare receiving requests for these services should get in touch with the Municipal Aid Administration pending the receipt of a bulletin giving full details of the procedure to be followed.

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## COLONEL SEELEY TRANSFERRED

Colonel Sam F. Seeley has been transferred from the Procurement and Assignment for physicians, dentists and veterinarians, to military duty. The Directing Board of Procurement and Assignment adopted a resolution expressing its appreciation for the valuable service which Colonel Seeley rendered during its period of organization and functions, and ex-

pressing to Colonel Seeley himself the thanks of the board and its gratitude for his unselfish devotion to the Procurement and Assignment Service, and their best wishes for his success in his new assignment.

No successor to Colonel Seeley has as yet been announced.

## ORIGINAL ARTICLES

### THE CORRELATION OF ROENTGEN RAY DIAGNOSIS OF LESIONS OF THE STOMACH AND DUODENUM WITH THE OPERATIVE FINDINGS \*

WITH SELECTED CASE REPORTS

By W. JAMES MARQUIS, M.D., and C. F. BAKER, M.D., Newark, N. J.

The roentgenologist is often asked by the clinician just how much dependence can be placed upon the roentgenological findings. In order to give an answer of value, it is necessary for the roentgenologist to review his work at intervals and check his diagnoses with the pathology that was demonstrated either at operation or at autopsy.

This study was undertaken so as to be able to more accurately evaluate our reported roentgenological findings in lesions of the stomach and duodenum. This seems a proper time to make such a study as diseases of the stomach and intestines are increasing in frequency. The editors of "Fortune Magazine" considered this subject of sufficient lay interest to feature an article in the December, 1941, issue of the magazine. Among other things, it was stated that there are over 500 brands of powders, pills and potions sold on the market for the relief of stomach disorders. In the period between the years 1901 and 1905 the United States *death rate* from peptic ulcers was 2.9 per 100,000 population. In 1907 this rate had risen to 6.8.

In 1911 the death rate for males from peptic ulcer was 4.2 per 100,000. In 1937 this had risen to 10.9. In females the death rate in 1911 was 3.2 and in 1937 had shown a slight decline. This article also brought out the fact that peptic ulcer afflicts particularly those who are intelligent, aggressive and sensitive. Peptic ulcer is rare among Southern Negroes, Orientals, children and the mental defectives. Ulcer is frequent among doctors, lawyers, executives, stock brokers, theatrical folk, etc. However, the income does not seem so great a factor, since the twenty-dollar-a-week pants-

presser is just as liable to be afflicted as the twenty-thousand-a-year executive. The most frequently afflicted age-period is between twenty and forty years.

Eighty per cent of peptic ulcers are in the duodenum, which means that they are found there four times as frequently as in the stomach. The total incidence of peptic ulcer cases in the United States was variously estimated between 320,000 and 11,000,000, and some authors estimate the incidence to run as high as 15 per cent of the total population. The article in "Fortune" states that British statistics show peptic ulcer as one of the leading causes of medical disability in army personnel. It was only twelfth among the causes of disability in medical cases in World War I.

According to an article presented by A. K. Gray<sup>1</sup> and associates of the Mayo Clinic during the year 1940, 373 duodenal ulcer cases and 108 gastric ulcer cases came to *operation* there. This is a ratio of duodenal to gastric ulcer of 3.1 to 1. Gray found, however, that gastric ulcer was diagnosed in 0.2 per cent, and duodenal ulcer in 3 per cent of the total number of patients registered at the clinic. Duodenal ulcer was thus *diagnosed* fifteen times as frequently as gastric ulcer.

#### METHOD OF STUDY

In beginning our statistical review, a list was made of all the patients who had roentgen examinations of the stomach and duodenum covering a three to five-year period in each of three hospitals with which we are connected, and also in our private office. Questionnaires were mailed to the patients examined at our

\*Read before the Section on Radiology of the Annual Meeting of The Medical Society of New Jersey, on April 22, 1942, in Atlantic City, N. J.

1. H. K. Gray, M.D.; Waltman, M.D., and J. T. Priestley, M.D.: Report of Surgery of the Stomach and Duodenum for 1940. Pro. Staff Mayo Clinic, November 12, 1941, Vol. 16, pp. 721-727.

private office, requesting information with regard to any operative procedures that had been carried out subsequent to our examination. The records of all of the patients who were examined in the hospitals were checked in regard to operative or autopsy findings. From these records we were able to obtain information in regard to 200 individuals that had been examined by either one or the other of us and who had had an operation within a reasonable time following our examination. The cases studied, therefore, represent a consecutive series, excepting those few individuals in which the operation did not occur within six months after the roentgen examination.

The roentgen diagnoses were classified as follows:

- Miscellaneous cases (few).
- Gastric ulcers.
- Gastric carcinomata.
- Gastro-enterostomized stomachs.
- Post-pyloric ulcer.
- Normal or negative findings with regard to stomach or duodenum, but with some lesion in the abdomen necessitating exploration.

We have also compared the result of this series with reports of other series already published.

TECHNIQUE

With regard to the technique used, we have found the use of the fluoroscope valuable, but our statistical results show it to be 5 per cent *less* accurate in diagnoses than when we used multiple eight-by-ten-inch films. Our routine technique consists of making numerous x-ray films of the stomach with the patient in the horizontal and prone positions. Fluoroscopic examinations are made when indicated. In seventy-six cases in this series fluoroscopy was combined with the films. We find that there was 86.9 per cent agreement in diagnosis when the cases were fluoroscoped, and 90.4 per cent in the cases that had only films. There was 89 per cent agreement in the series as a whole. It must be remembered, however, that many of the more difficult cases were in the group that was fluoroscoped.

We do not use spot films regularly, but in

those cases in which we have used them we have felt that we have not obtained much additional help, and in fact we tend to become more confused, particularly if pressure has been used over the cap. It is most difficult to differentiate between normal variations in the mucosal pattern and minute changes due to pathology.

DISCUSSION OF ERRORS

In this series the greatest number of mistaken diagnoses concerned *cap ulcers*. In six of fifty-three cases there was some degree of error. Among various causes for misinterpretation, Moore<sup>2</sup> cites unusual *tension* of the muscles of the abdominal wall causing pressure over the stomach and cap. In uncertain findings we recommend the use of antispasmodics over several days and reexamination. At the second examination there is apt to be less spasm and no apprehension on the part of the patient. We believe this routine will improve the accuracy of diagnoses a few per cent.

ROENTGEN DIAGNOSIS

The Roentgen diagnoses were divided, as shown in Table I.

TABLE I.  
ROENTGEN DIAGNOSES

Miscellaneous .....	7
Gastric ulcer .....	12
Gastric carcinoma .....	14
Gastro-enterostomy .....	20
Duodenal ulcer .....	53
Normal .....	94
<hr/>	
Total .....	200

There was only one colored patient, one Japanese and one Chinese in the group. Of the hospitalized cases, one out of five individuals that had a roentgen examination came to operation, whereas of the ambulant cases only one out of about ten had operative procedures.

MISCELLANEOUS CASES

The smallest number of patients was in this group of seven cases. The x-ray diagnoses and operative findings are recorded in Table II.

2. A. B. Moore, M.D.: Diagnoses of Gastric and Duodenal Diseases. Factors Leading to Roentgenological Error. New Orleans Medical & Surgical Journal, 1929, lxxxii, 341-345.



TABLE II.—MISCELLANEOUS CASES

<i>X-Ray Diagnoses</i>	<i>Operative Findings</i>
1. Adhesions pyloric area .....	Adhesions and malignancy (primary was probably pylorus).
2. Gastritis .....	Carcinoma of stomach.
3. Extrinsic lesion .....	Carcinoma of stomach.
4. Pyloric obstruction .....	Pyloric stenosis (Rammstead operation).
5. Obstructive lesion .....	Congenital defect in duodenum.
6. Gastric polyp .....	Gastric polyp.
7. Diaphragmatic hernia .....	Diaphragmatic hernia.

In this group the sex distribution was four males and three females, the ratio of male to female being 1.3 to 1. The age distribution was one infant six weeks of age; two adults between forty and forty-nine years of age; two between fifty and fifty-nine years; one sixty-six and one eighty years. No lesions were missed entirely, but there were two lesions incorrectly diagnosed. There was one lesion that was not identified and there was one lesion in which the operative findings were not conclusive. The roentgen diagnosis in the latter case was "adhesions about the pyloric area" and at operation extensive adhesions were found. A biopsy revealed carcinoma, and the primary lesion was believed to be located in the pylorus.

Case Report. (1) G. E., aged 49, female. Symptoms at onset—Constant, dull aching pain about navel, six months duration. Not related to meals or time of day. One evening when about to partake of food felt giddy and nauseated. Had hemoptyses, lost several ounces of blood. Refused hospitalization. Pain persisted and became more severe. On August 20 had severe attack lasting for hours. Hospitalized August 22nd. Denied jaundice or nausea. Pain not related to food or alcohol. "Alcohol made pain numb." Had cholecystectomy, appendectomy, fistula in ano 18 years ago.

*Roentgen Findings:* Adhesions about pylorus.

*Operative Findings:* Dense adhesions.

Biopsy: Carcinoma, origin not definite but probably pyloric portion of stomach.

#### GASTRIC ULCER

In this group there were twelve cases of which eight were males and four were females, the male to female ratio being 2 to 1. The age periods were: one in the third decade of life; two in the fourth decade; six in the fifth decade; one in the sixth decade; one in the seventh decade; and one unknown. There was one frank error of commission, in which the

roentgen diagnosis of gastric ulcer was made and none was found at operation.

Case Report: D. P., aged 42, male, American. Three years ago developed pain in left upper quadrant immediately after meals. Treated and was relieved. Now recurrence of symptoms. Gall-bladder and appendix removed. Patient died 13 days post-operative.

Roentgen Findings—appearance of a small niche on the lesser curvature above the incisura angularis.

Operative Findings—No evidence of a lesion in the stomach was noted.

#### GASTRIC CARCINOMA

There were fourteen cases in this group. Sex distribution was ten males and four females (the ration of male to female being 2.5 to 1). The age distribution—five cases between forty and forty-nine, four cases between fifty and fifty-nine, two cases between sixty and sixty-nine, two cases between seventy and seventy-nine, one age unknown. There was one frank error of commission. In this case Roentgen findings appeared to indicate a large crater on the greater curvature, which was diagnosed as carcinoma. At operation, however, this area was found to be normal. The appearance of a niche on the greater curvature persisted in the re-ray. It suggested a hypertrophic gastritis, but the surgeon reported the stomach normal.

Case Report: R. S. History not available.

*Roentgen Diagnosis:* Ulcer on greater curvature not found by surgeon.

There were four other cases in which carcinoma was found, making a total number of eighteen cases in which carcinoma was present. Of these eighteen cases two were missed on the roentgen examination. In five cases the diagnoses were in conflict and in eleven cases the diagnoses were in agreement.

Walters and his associates<sup>3</sup> state that in a group of 2,469 cases of carcinoma found at operation, twenty-five were missed by the roentgenologist, equaling 1 per cent; 585 cases were otherwise diagnosed, equaling 23.7 per cent; and in 1,859 the diagnoses were in agreement, equaling 75.3 per cent.

Case T. G. illustrates the difficulties in making an early roentgen diagnosis of carcinoma. Roentgenologic diagnosis—Cap deformed and a *fresh post-pyloric ulcer* present. The surgeon diagnoses the cap as normal, but felt a little thickening in the prepyloric area. This was resected and the pathologist diagnosed *malignancy*.

Case Report: T. G., age 42, male, American. Tarry stools; sudden collapse; no pain or shock present. Abdomen not tender or rigid. Patient had previous gastric ulcer and gastro-enterostomy.

*Final Diagnosis:* Papillary carcinoma of stomach.

As has been brought out by others, it is impossible in some instances to make a differential diagnosis between *simple benign gastric ulcer and carcinoma* judging by the size of the crater. There were two cases with *similar clinical findings, roentgenologically one showed a large crater. Pathologically this ulcer was found to be benign. The other patient had a much smaller crater which was found to be carcinoma.*

#### GASTRO-ENTEROSTOMIZED STOMACHS

There were twenty cases in this group, consisting of fourteen males and six females. (This gives a male to female ratio of 2.3 to 1.) In ten of this group the gastro-enterostomies were functioning normally and nine were in agreement with the operative findings. In one case it was impossible to determine from the operative record the exact condition that was present. In three cases gastro-jejunal ulcer was diagnosed and found at operation. In four cases there was evidence of obstruction, either at the stoma or in the duodenum, and some type of obstruction was found in these four cases at operation. In three cases the gastroenterostomy was not described in the

roentgen report, and in none of these three was there any evidence of either obstruction or gastro-jejunal ulcer found at operation.

#### DUODENAL ULCER

There were fifty-three cases in this group, of which forty-one were males and twelve females (the male to female ratio being 3.4 to 1). The age distribution was as follows: Three were between twenty and twenty-nine years, six were between thirty and thirty-nine years, eleven were between forty and forty-nine years, seventeen were between fifty and fifty-nine years, ten were between sixty and sixty-nine years, six were of unknown age. There was frank disagreement in two cases or 3.5 per cent. *The roentgen diagnosis was questionable in four cases.* Of these four cases two were found to be normal and two had carcinoma. In six other cases a lesion was found, but from the operative record its exact site was indeterminate. In forty-one cases a lesion was found and described as definitely being in the duodenum, or *in 82.5 per cent the roentgen diagnoses and operative findings were in full agreement.* You will note, however, that in only 7 per cent was there no lesion found. Of the fifty-three cases, twenty-five were found to be obstructed at the pylorus.

Cases C. G. and C. K. illustrate the difficulties met in making a diagnosis of a lesion in the duodenum and where x-ray was not of great aid.

Case Report: C. G., male, age 53, German.

Vomiting blood. Five years ago patient noticed gastric distress after noonday meal—intermittent attacks, recurring more often, and daily had heavy pain at 2:30 and 8:00-9:00 p.m., usually lasting from thirty minutes to an hour. Three weeks ago the pain lasted all night and patient vomited "between two and three quarts of blood between 8:00 p.m. and 1:00 a.m.—none vomited since." Abdomen distended and tympanic. No tenderness nor abnormal masses palpated.

*Final Diagnosis:* Chronic productive cholecystitis—chronic atrophic appendicitis.

Case Report: C. K., female, aged 56, German. General health has always been good—indigestion noted for several years, but appetite remained good. Coffee-ground-like material vomited three years ago. No weight loss, no jaundice or clay-colored stools. No pain. Tenderness in left upper quadrant.

*Final Diagnosis:* Duodenal ulcer—cholelithiasis.

3. Waltman Walters, M.D.; Howard K. Gray, M.D., and J. T. Priestley, M.D.; Malignant Lesions of the Stomach. J. A. M. A., Nov. 15, 1941; vol. 117, pp. 1675-1679.

The roentgen diagnoses in these two cases was indeterminate, the cap appearing irregular in some films and fairly normal in others. Both gave a history of vomiting blood. Yet at operation the man C. G. had no cap ulcer but the woman C. K. did. Both were explored by the same surgeon. Thus, in spite of the statistics that ulcer is more frequently found in men, the rule did not help in this instance.

Two cases, J. D. and A. T., illustrate some of the difficulties in making a differential diagnosis between carcinoma of the pylorus and an obstructive post-pyloric ulcer.

Case Report: J. D., age 62, male, American.

Patient unable to retain any food or fluids for past two weeks. Considerable loss of weight. Patient had pain almost immediately after eating, had had similar spells previously; constipated; urethral dilatation every three months; previous urinary bladder operations four and seven years ago.

*Final Diagnosis: Duodenal ulcer with pyloric obstruction. Recovered.*

Case Report: A. T., female, age 68, American. Four weeks patient had loss of appetite without loss of weight. G. U. negative; some distress in mid-epigastrium. No pain.

*Final Diagnosis: Carcinoma of pylorus—metastases to liver.*

In both these patients the history of obstruction was relatively short, the degree of dilatation of the stomach about the same and a cap could not be demonstrated in either. The appearance of the prepyloric area in the second case (A. T.) was suggestive of carcinoma and was so reported by the roentgenologist. At operation the first case (J. D.) was found to have an old sclerosed cap from ulcer. The second case (A. T.) proved to be obstructed from a carcinoma in the prepyloric area.

Another case, G. M., presented in the roentgenogram the appearance of an obstructive lesion at the outlet similar to those due either to carcinoma or a sclerosed cap ulcer. In many films the lesion appeared to be in the cap. The surgeon reported the ulcer as being at the pylorus. In many of these cases it is impossible to determine the exact cause of the obstruction, except by an *exploratory operation*. Even then it may be difficult as the induration

about an ulcer at the outlet may be so marked it will resemble a neoplasm, or the exact site of the ulcer in relation to the pylorus may be difficult or impossible to determine.

#### NORMAL

In this group there are ninety-four cases in which fifty-eight were male and thirty-six female (the male to female ratio being 1.6 to 1). The age distribution was as follows: three below nineteen years, eight between twenty and twenty-nine years, sixteen between thirty and thirty-nine years, eighteen between forty and forty-nine years, twenty-four between fifty and fifty-nine years, thirteen between sixty and sixty-nine years, seven between seventy and seventy-nine years, one at eighty, four of unknown age. There were two in which there was frank disagreement or 2.1 per cent. One patient had a carcinoma at the cardiac end of the stomach, which was not recognized in the roentgen examination but which was present at the operation six months later. At this time there was a one-inch involvement of the cardia, most of the lesion being beneath the diaphragm.

There was one case of ruptured gastric ulcer. On reviewing the films we felt that this condition should have been recognized at the time of the roentgen examination.

#### RECAPITULATION

##### SEX DISTRIBUTION

	Male	Female	Ratio
Miscellaneous	4	3	1.3 : 1
Gastric ulcer	8	4	2 : 1
Carcinoma	10	4	2.5 : 1
Gastroenterostomy	14	6	2.3 : 1
Duodenal ulcer	41	12	3.4 : 1
Normal	58	36	1.6 : 1
Total	135	65	2.07 : 1

It will be noted from the table that the average ratio of male to female was 2.07 to 1. The highest ratio was in the group diagnosed as cap ulcer, in which the ratio was 3.4 to 1 and the lowest was in the miscellaneous group, where the ratio was 1.3 to 1.



AGE DISTRIBUTION							Total
	Misc.	GU	CA	GE	DU	Normal	
0-19	1					3	4
20-29					1	8	11
30-39		1		5	6	16	28
40-49	2	2	5	8	11	18	46
50-59	2	6	4	4	17	24	57
60-69	1	1	2		10	13	27
70-79		1	2	1		7	11
80	1					1	2
Unknown							14

It will be noted from the table that in most of the groups the greatest number of cases occurred between the ages of 50 and 59. Two exceptions, however, were those of the group diagnosed as carcinoma, the greatest number of lesions occurring between 40 and 49, and in those cases that had a gastroenterostomy performed previous to roentgen examination. It may be that the greatest number of cases occurred between the 50 to 59 age group because we are considering in this study only those cases that came to operation. Thus, anyone having either a gastric or duodenal ulcer is usually given the benefit of medical treatment until some acute episode, such as hemorrhage or obstruction intervenes later in life, which necessitates operative procedures. An individual is also inclined to defer operation until the symptoms become so pronounced or recur so frequently that he becomes willing to submit to operative procedures.

DISAGREEMENT				
	Omission	Com- mission	Misnamed or Some Question	Operation Finding Question
Miscellaneous			3	
Gastric ulcer		1	1	
Carcinoma		1	1	
Gastroenterostomy				1
Duodenal ulcer		2	4	6
Normal	2			
<hr/>				
Total	2	4	9	7
<hr/>				
Percentage	1	2	4.5	3.5
<hr/>				
Frank disagreement			3%	
Some disagreement			8%	
Total possible error			11%	
Known agreement			89%	

It will be noted from this table that there were only two errors of omission in the total series, or a 1 per cent error of omission. There is a total of four errors or 2 per cent of commission. In addition there were nine cases in which the lesion was misnamed and there were seven cases in which the operative findings were somewhat questionable. As stated previously, the greatest number of errors occurred in the group that was diagnosed as duodenal ulcer.

SIMILAR SERIES IN LITERATURE

D. B. Harding<sup>4</sup> in 1929 reported on a series of 100 operated cases, in which 10 per cent showed some degree of disagreement; three cases were diagnosed a lesion at the outlet; two as multiple ulcers, these being only partially correct; one carcinoma of the pylorus, which also had an ulcer of the duodenum. There were four cases in which there was frank disagreement. One case indicated deformity of the pylorus, but was found to be normal at operation. One case diagnosed to be normal had an ulcer 4 cm. from the pylorus. One cap was called normal but an ulcer was found at operation. One cap was called deformed from ulcer and was found to have adhesions.

Jordan<sup>5</sup> reported on 120 cases of resected stomach, found ninety-one peptic ulcer cases, of which forty-nine were in the duodenum and nineteen were obstructed; twenty-three were gastric and there were eighteen constricted jejunal ulcer, twenty-five had carcinoma and four had a benign lesion, not ulcer. In this series you will note the duodenal ulcer to gastric ulcer ratio was only 2.1 to 1. In our series there were ten cases of gastric ulcer found at operation and forty-one cases that definitely had post-pyloric ulcer; the duodenal ulcer to gastric ulcer ratio being 4.1 to 1.

4. D. B. Harding, M.D.: A Roentgen Study of Lesions of the Stomach and Duodenum, with an Analysis of Errors in Diagnoses, *American Journal of Roentgenology and Radium Therapy*, July 1934, xxii, 26-42.  
5. Sara M. Jordan, M.D.: End Results of Radical Surgery of the Gastrointestinal Tract. *J. A. M. A.*, Feb. 15, 1941, vol. 116, pp. 586-590.

## NEUROSYPHILIS IN RELATION TO OPHTHALMOLOGY\*

IRVIN LEVY, M.D., Trenton, N. J.

The effects of syphilis on the conducting part of the sensory portion of the optical system are more frequently observed by ophthalmologists and neurologists than by other members of the medical profession. We would all like to know how common these effects are. From a statistical standpoint, it can be stated that of the people who have syphilis only about 10 per cent bear clinical evidence of what we classify as neurosyphilis. Only 5 per cent of this latter group have any clinical evidence of tabes dorsalis. Of this 5 per cent who develop tabes, about 10 per cent develop optic atrophy. So, in general, it might be well to recapitulate and state that out of 2,000 patients who are known to be syphilitic, about 200 have neurosyphilis and 10 develop tabes. Of the 10 tabetics only one is liable to develop optic atrophy. This group, on a percentage basis, is about the same as the group of syphilitic patients who develop optic atrophy without tabes.

From these facts, we can deduce that about two out of every 2,000 known luetics will develop optic atrophy.

### OPTIC ATROPHY

The evaluation of optic atrophy of luetic origin offers its own problems from the standpoint of pathogenesis and treatment. There is some question concerning the true nature of the change which takes place in the nerve under these circumstances. Dr. Henry P. Wagener states that the involvement occurs in three distinct ways:

1. Optic neuritis.
2. Axial or retrobulbar neuritis.
3. Simple progressive primary atrophy (77.5 per cent of the nerve lesions are of this type).

The therapy has not been satisfactorily worked out. Hyperpyrexia has a place in this consideration; modifications of the Swift-Ellis treatment also have their advocates, as

does the usual anti-luetic regime. One should not overlook the conclusion of Dr. Moore, that the progress of primary syphilitic optic atrophy may be completely arrested by the use of either subdural treatment or malaria, more often by the latter.

### GUMMA

Gummas of the brain are not common. If brain tumors from all sources are considered, less than one out of every 100 brain tumors have syphilis as an etiological factor. In spite of the infrequency with which gummas affect the optical apparatus, it is well to keep this in mind in all lesions of the chiasm. Among the signs which may help point to its presence are:

1. Either clinical or serological evidence of syphilis.
2. Absence of signs of bone destruction.
3. Evidence of increased intra-cranial pressure, as in any lesion increasing in size.
4. The presence of an altitudinal hemianopsia which, as Dr. Peter has pointed out, is the most common defect found in the visual field with this lesion.
5. The rapid growth as contrasted with most other chiasmal lesions which are more frequently insidious in nature.

Gummas making pressure on the optic nerve, tract, or visual cortex cause neurological signs characteristic of pressure or blocking in that particular locality.

### ARACHNOIDITIS AND ANATOMICAL HIGHLIGHTS

Comparatively recently, ophthalmologists and neurologists have become increasingly aware of the condition known as arachnoiditis, particularly as to localized arachnoiditis in the region of the cisternal chiasm which presents a chiasmal syndrome of optic nerve atrophy and temporal field defects. In this syndrome there is an absence of pituitary signs, and a normal sella turcica is revealed by x-ray.

At this point we will briefly review some of the anatomical highlights and variations of this part of the central nervous system.

\* Read before the Eye, Ear, Nose and Throat Section (Symposium on Syphilis and Its Relation to Eye, Ear, Nose and Throat) of the Annual Meeting of The Medical Society of New Jersey, April 22, 1942, under the title "Chiasm and Tract Lesions".

You will recall that the optic nerve collects its fibers from the retina, passes from the posterior surface of the eyeball through the orbit and optic foramen into the cavity of the skull, to the chiasm. Hence, three divisions are distinguished in the optic nerve:

1. The intra-ocular termination, which is found within the sclera.

2. The orbital portion from the eyeball to the optic foramen is bent like the italic letter *f*. Owing to this, the eyeball can move freely within wide limitations.

3. The intra-cranial portion from the optic foramen to the chiasm is very short—scarcely one centimeter in length. Its shape is flat.

At the chiasm the two optic nerves join together. There the nasal fibers decussate and reappear on the proximal side of the chiasm as the optic tracts. The crossed fibers comprise about three-fifths of the optic tract; the temporal or uncrossed about two-fifths. From the chiasm, which lies in the optic groove of the body of the sphenoid bone, usually directly in front of the infundibulum and above the hypophysis, the optic tracts pass backward diverging as they go and winding about the crus cerebri to the primary sub-cortical optic centers. The most important of these are the external geniculate body and superior colliculus. Thence, the fibers pass to the oculo-motor nucleus and mainly to the visual cortex.

The pituitary gland has anatomical variations which rarely may locate it in front of rather than behind the chiasm. It is also well to note that very occasionally we may have to consider variations in the bony structure of the sphenoidal fosa. Marked sclerosis of the internal carotids has been suggested as a cause of bi-nasal hemianopsia. This is rare. Part of the optic nerve and chiasm are enveloped in the coverings of the brain.

Differential diagnosis of the above mentioned arachnoiditis is difficult because symptoms are varied; no one, alone, being pathognomonic; even similar groupings may be met with in other conditions. The slow progress of the condition suggests this diagnosis. At times there may be some papilloedema as contrasted with a primary optic atrophy. A helpful diag-

nostic aid may prove to be an encephalogram. Ventriculography offers little help. One should always be on guard for localized arachnoiditis. If the chiasmal syndrome is present and medical treatment for syphilis is of no avail, operative intervention is indicated.

In a review of a series of 129 cases presented to the French Ophthalmologic Society in 1937, by Drs. Bollach, David, and Puech, the following conclusions were drawn:

1. Opticochiasmic arachnoiditis represents 27 per cent of all neurosurgical diseases that occur in the hypophysial region.

2. Sixty per cent of the cases occurred in adults between 30 and 40 years of age.

3. Operative mortality is low.

4. Cure or improvement was obtained in 37 per cent of the cases.

5. Early surgical intervention appears to be all important in the preservation of vision.

#### ARGYLL-ROBERTSON PUPIL AND ADIE'S SYNDROME

Whenever a physician sees an irregular or fixed pupil it usually behooves him to rule out syphilis of the central nervous system.

No discussion of syphilis of the nervous portion of the optical apparatus should omit the Argyll-Robertson pupil characteristics:

1. It is usually bilateral.

2. It is a myotic pupil.

3. It does not respond to light.

4. It reacts to accommodation.

5. It does not usually react well to mydriatics or cycloplegics.

In addition to these pupillary findings, the fundus and vision are normal.

If the above characteristics are present, the patient has syphilis of the central nervous system. Whenever the Argyll-Robertson pupil is discussed, Adie's syndrome (non-syphilitic disease simulating tabes dorsalis) should also be mentioned.

In 1931 Dr. Adie described five cases presenting a syndrome which was frequently diagnosed as tabes but was not tabes. This syndrome was characterized by the tonic pupil and the loss of one or more deep reflexes. These symptoms are chronic. They do not get worse or better and they are not due to syphilis.



Drs. J. McDowell McKinney and Maurice Frocht believe that Adie's syndrome includes typical and atypical types. The typical case shows unilateral tonic pupil and absence of one or more deep reflexes. These signs remain stationary, do not otherwise impair the patient's health and tend to occur in younger people, more frequently in females than in males, 5:1. Atypical cases show:

1. Tonic pupil alone.
2. Atypical phases of the tonic pupil alone.
3. Atypical phases of the tonic pupil and absence of deep reflexes.
4. Absence of deep reflexes and no pupillary changes.

The tonic reaction is characterized by the slow response to the stimulus usually with a latent period or delay before the response begins to take place. Dr. Moore states that, "One case showed a delay of five minutes before the reaction in accommodation began." The tonic pupil contracts slowly and may eventually become smaller than the normal. When the stimulus is removed, it may continue to contract (rare), may remain stationary for several seconds (the rule), or may proceed slower than that of the preceding contraction, and many seconds or even minutes elapse before it regains its usual resting size. A typical tonic

pupil is larger than normal and unilateral. It is regular in outline. It dilates well with mydriatics and contracts with eserine. Repetition does not facilitate the movement as it does in myotonia of skeletal muscle.

The etiology is undetermined. It is possibly a disease *sui generis*. It is perhaps heredo-degenerative but it is not syphilitic. It may also possibly be due to irritation of the peripheral sympathetic nerves following chronic inflammation in the pharyngeal region.

#### CONCLUSION

In conclusion, it may be stated that the effects of syphilis on the optic chiasm and the optic nerve are not frequently seen. Probably the most common intra-cranial effects of syphilis are not on the brain tissue itself but on the vascular tree with its syphilitic endarteritis, aneurisms, and ruptured vessels. This vascular involvement may produce the typical cerebral accidents which are so familiar to all of us. The most discouraging feature of syphilis of the visual pathways is that a satisfactory method of treatment has not yet been developed. The chief, and most satisfactory avenue of approach, is the general treatment of the syphilis itself and the best treatment of syphilis itself is its prevention.

154 West State Street

### EFFECT OF TONSILLECTOMY ON RESPIRATORY INFECTIONS IN CHILDREN

The tonsils are undoubtedly responsible for many upper respiratory infections especially in children subject to tonsillitis and to cervical adenitis and can be considered as playing an important rôle in these infections. Tonsillectomy is desirable in such children.

The adenoids appear to be a causative factor in some children who develop frequent colds and middle ear infections. In the age period of 3 to 7 years the adenoid structures are particularly a menace to many children and their removal does assure some protection against similar recurrent attacks. Adenoidectomy is advised in such children either alone or along with a tonsillectomy. For the relief and protection against sinusitis and nasal allergy no statistical evidence is available to jus-

tify any protection by either the removal of the tonsils and adenoids or both organs. In the production of these clinical manifestations the tonsils and adenoids seem not to play any significant part.

Evidence obtained in this study does not support the opinion that laryngitis, bronchitis, and pneumonia can be reduced in incidence by removing the tonsils and adenoids. It appears that laryngeal, bronchial and pulmonary infections are not dependent upon the presence or absence of the tonsils and that these lymphoid structures do not play a significant rôle in lower respiratory diseases. — (Author's Abstract.) Albert D. Kaiser, Bull. New York Acad. M., 18:338-346, May, 1942. (Clinical Abstracts, 1942.)

## THE EFFECT OF AMPHETAMINE (BENZEDRINE) SULPHATE, PROPADRINE HYDROCHLORIDE AND PROPADRINE HYDROCHLORIDE IN COMBINATION WITH SODIUM DELVINAL ON THE APPETITE OF OBESE PATIENTS \*

S. WILLIAM KALB, M.D., Newark, N. J.

That loss of weight in obese as well as in normal patients will occur when energy intake is less than the energy output, has been well established. However, numerous adjuvants directed towards inhibiting the appetite or increasing the metabolic rate have been employed along with low caloric diets. Among these are the sympathomimetic drugs as well as thyroid and related substances.

Benzedrine (phenylisopropylamine) or amphetamine sulphate has a chemical structure allied to phenylethylamine, ephedrine and propadrine. Ephedrine causes relaxation of the musculature and inhibition of the peristalsis in the gastro-intestinal tract. As a result there is a delayed emptying of the stomach.<sup>1</sup> Amphetamine (benzedrine) sulphate is similar in action to ephedrine but in addition has the ability to stimulate the higher centers.<sup>1</sup>

Detrick et al<sup>2</sup> demonstrated that in low concentrations, amphetamine (benzedrine) sulphate had no effect on excised smooth muscle while higher concentrations caused inhibition of cat ileum and duodenum before contraction of the smooth muscle occurred. Boyd<sup>3</sup> reported that contraction of the segments of small intestine in rabbits occurred at a concentration of 0.01 to 0.001 per cent. Goodman and Gilman<sup>1</sup> concluded from the literature that the action of amphetamine (benzedrine) sulphate depended on the phase of activity of the gastro-intestinal tract; a normal stomach was first stimulated and then followed by inhibition and delayed emptying time; the pylorus more often showed increased tone; the action on the small intestine was uncertain; spasticity of the colon was relaxed and gastric acidity was not influenced. Myerson et al<sup>4</sup> found a

decrease in the volume of gastric juice but an increase in acidity. The biliary tract was not influenced by amphetamine (benzedrine) sulphate,<sup>5,6,7</sup> whereas, Flexner and his co-workers<sup>8</sup> observed relaxation of the gall-bladder after administration of this drug to cats. Van Liere and Sleeth<sup>9</sup> stated that amphetamine (benzedrine) sulphate caused delayed gastric emptying and Myerson and Ritvo<sup>10</sup> demonstrated a relaxed gastric musculature and the abolition of gastro-intestinal spasm.

The majority of these actions, therefore, tend to reduce the appetite as was found by Lesses and Myerson,<sup>11</sup> McLagan<sup>12</sup> and Berman.<sup>13</sup> Bruch<sup>14</sup> suggested that decreased appetite and weight loss were due to the effect of amphetamine (benzedrine) sulphate on the hypothalamus. This decrease of appetite as well as the effect of amphetamine (benzedrine) sulphate on the gastro-intestinal tract have made it easier for patients to adhere to low caloric diets.<sup>11, 15, 16, 17, 18, 19, 20, 21.</sup>

Weight loss was observed but weight was regained on discontinuing amphetamine (benzedrine) sulphate.<sup>22, 23, 24, 25</sup> Animals, too, have

\* From the Nutrition Clinic, Department of Medicine, New York Post-Graduate Medical School and Hospital, Columbia University.

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been shown to lose weight though tolerance to this drug did occur.<sup>26,27</sup> Rosenthal and Solomon<sup>15</sup> suggested that amphetamine (benzedrine) sulphate possibly prevented the retention of excess water in the tissues and thereby aided weight loss. Other investigators felt that decreased weight was due to increased activity and metabolism, decreased appetite, diminished gastric tone and stimulation of the higher centers.<sup>11, 17, 20, 28, 29, 30</sup>

Despite these findings, Kalb<sup>31</sup> demonstrated that amphetamine (benzedrine) sulphate, thyroid extract or combinations of these failed to increase weight loss over that resulting from low caloric diets alone. In addition, a study of 1200 obese patients given amphetamine (benzedrine) sulphate showed that 40 per cent of these patients developed anorexia;<sup>32</sup> the toxic effects of these drugs were also noted in the latter study as well as in the review by Ivy.<sup>33</sup>

Propadrine has a similar action to ephedrine and a greater pressor action but has less power to stimulate the central nervous system.<sup>34</sup> Barbiturates, e.g., sodium delvinal in adequate doses, also depress the action of smooth muscle but in a varying degree. The emptying time of the stomach is delayed in animals.<sup>35</sup>

In this study, an attempt was made to evaluate the effect of amphetamine (benzedrine) sulphate, propadrine hydrochloride and propadrine hydrochloride in combination with sodium delvinal on the appetite of obese patients maintained on low caloric diets. Furthermore, all side effects caused by these drugs were noted.

#### METHOD

Eighteen hundred and eighty patients who were 10 to 192 per cent overweight were placed on a high protein diet ranging from 600 to

1500 calories. Only slight caloric adjustments were made in the diet during the period of observation.

Twelve hundred patients received 10 to 20 mg. of amphetamine (benzedrine) sulphate twice daily for 4 to 36 weeks. Four hundred and sixty-four individuals were given  $\frac{3}{4}$  grain propadrine hydrochloride twice daily for 4 to 16 weeks. Two hundred and sixteen patients received  $\frac{3}{8}$  grain propadrine hydrochloride in combination with  $\frac{1}{4}$  grain sodium delvinal twice daily for 4 to 16 weeks. Medication was discontinued when untoward reactions occurred. A control group of one hundred patients received no other therapy other than the low caloric diet.

#### RESULTS

*Effect on Appetite*—The effect on the appetite by the various drug adjuvants is represented in Table I. It is evident that 12 per cent of the patients who received no medication had a diminution in appetite. With amphetamine (benzedrine) sulphate, propadrine hydrochloride and propadrine hydrochloride in combination with sodium delvinal, anorexia develops in 40 to 45 per cent of these patients.

*Side Effects*—Table II summarizes the untoward side effects resulting from the submaintenance diet alone and from the various drugs used. This protocol demonstrates that the addition of sodium delvinal to propadrine hydrochloride reduces the side effects of the low caloric diet and of amphetamine (benzedrine) sulphate and propadrine hydrochloride.

Amphetamine (benzedrine) sulphate produces a sense of well being which is not observed in patients maintained on the subcaloric diets with or without the other drugs. Propadrine hydrochloride alone, causes less side effects than amphetamine (benzedrine) sulphate with the single exception of dyspnea.

#### SUMMARY AND CONCLUSIONS

1. Amphetamine (benzedrine) sulphate, propadrine hydrochloride and propadrine hydrochloride in combination with sodium delvinal diminished the appetite in approximately 40 per cent of 1880 patients with obesity maintained on low caloric diets. In 100 obese patients used

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as controls, a submaintenance diet alone produced anorexia in only 12 per cent of these.

2. Amphetamine (benzedrine) sulphate caused more side effects than propadrine hydrochloride. The addition of sodium delvinal to propadrine hydrochloride practically abolished the side effects of this drug.

3. Amphetamine (benzedrine) sulphate produced a sense of well being in obese patients maintained on subcaloric diet which was not observed in any of the other groups studied.

TABLE I.

THE EFFECTS OF INDICATED SYMPATHOMIMETIC DRUGS  
ON THE APPETITE OF OBESE PATIENTS

Medication	No. of Patients	No Change Per Cent	Diminished Per Cent
Amphetamine (benzedrine) sulphate	1200	60	40
Propadrine hydrochloride	464	55	45
Propadrine hydrochloride with sodium delvinal	216	56	44
Control	100	88	12

TABLE II.

INCIDENCE OF TOXIC MANIFESTATIONS NOTED ON  
ADMINISTRATION OF INDICATED SYM-  
PATHOMIMETIC DRUGS

Complaint	Amphetamine (Benzedrine) Sulphate Per Cent	Propadrine Hydrochloride Per Cent	Propadrine Hydrochloride with Sodium Delvinal Per Cent	Control Per Cent
Dryness of mouth	66	7	5	3
Palpitation	31	15	2	9
Halitosis	25	15	16	14
Insomnia	24	5	1	2
Muscular pain	21	10	2	2
Headache	20	16	3	16
Weakness	16	17	4	15
Dizziness	12	10	2	9
Nervousness	11	7	1	5
Dyspnea	1	21	6	1
Total No. of Patients	1200	464	216	100

CONNECTICUT MEDICAL CARE

The Medical Society of Connecticut has prepared and issued an illustrated booklet which visualizes for the public the available medical services provided for their protection and alleviation as needed. The close relationships of these services to other state and community services is shown—especially those of the hospital and nurse—but also to industry, transportation, dentistry, food supply, laboratory, recreation, education, and rehabilitation. The services which only a physician can properly provide are shown in simple illustrations

with a simple text, so that the patient can readily understand the extent and importance of the contributions made by the medical profession. Every picture is a familiar scene to the profession, but it is likely that the public has rarely had so comprehensive a view of medical work so understandably presented. Here is a Public Relations project of merit and one which should prove to be most effective in the achievement of the purpose for which it was carried on. The headquarters of the Society are in New Haven (258 Church Street).

A LESSON FROM A DEATH CERTIFICATE

NUMBER FORTY-SIX

Gravida 1, para 0. Patient entered hospital at full term and had showed no abnormal symptoms except a gain in weight of 40½ lbs. (More than enough.) Blood pressure 130/90, urine normal. (Bordering on toxemia.)

A medical induction was not successful and patient was discharged. Readmitted 10 days later and a medical induction again tried which failed and patient again discharged.

Readmitted 10 days later in active labor. Delivered a live baby at 10 a. m. and at 2 p. m., had a convulsion and died.

Why discharge a full-term patient bordering on eclampsia when medical induction is not successful? Why not try a surgical induction and get results?

One cannot flirt with toxemia.

A. W. BINGHAM, M.D.

## OVARIAN TUMORS COMPLICATING PREGNANCY

### MATERNAL WELFARE ARTICLE NUMBER SEVENTY-FIVE

R. A. MacKENZIE, M.D., F.A.C.S., Asbury Park, N. J.

One's interest in any subject is most acute when case material is or has recently been encountered. The four case problems of ovarian tumors complicating pregnancy came to my care in close succession and naturally aroused my greater interest and prompted study of this condition. These illustrative cases will be presented.

In reviewing the maternal deaths reported to the Maternal Welfare Committee of our State Medical Society during 1940, there was noted one instance of a patient with labor complicated by an obstructing ovarian mass. Death followed Cesarean operation. This seemed to give added point to a brief discussion of ovarian tumors in relation to obstetrics.

Classifications of ovarian pathology are numerous and confusing. Dr. H. C. Taylor, Jr., in a paper titled "Changing Conceptions of Ovarian Tumors" published in the American Journal of Obstetrics and Gynecology in October, 1940, offers a classification based primarily on histogenesis which seems extremely helpful. This classification is reprinted here:

- I. Dysfunctional cysts of the follicle and corpus luteum.
- II. Endometrial cysts and endometriosis.
- III. Primary neoplasms of the ovary.
  - A. Epithelial tumors.
    1. Serous cystadenoma and cystadenocarcinoma.  
Special type: Adenoid cystic fibroma (Frankl).
    2. Pseudomucinous cystadenoma and cystadenocarcinoma.  
Special type: Mucous fibroepithelioma (Brenner).
  - B. Connective tissue tumors.
    1. Fibroma and fibrosarcoma.
    2. Rare connective tissue tumors (Myoma, lymphangioma, etc.)
  - C. Teratomas.
    1. Dermoid (cystic teratoma).
    2. Complex (solid) teratoma.  
Special type: Struma ovarii.
  - D. Tumors arising from the specific cells of the gonad.
    1. Granulosa cell tumor.  
Special types:
      - a. Folliculome lipidique (Lecene)
      - b. Theca cell tumor.

2. Arrhenoblastoma.  
Special type: Testicular adenoma (Pick)
  3. Dysgerminoma.
- E. Doubtful tumors.
1. Endothelioma.
  2. Hypernephroma.
  3. Mesonephroma (Schiller).

#### IV. Metastatic tumors of the ovary.

With this in mind we can better give thought to how any of these conditions may complicate the course of pregnancy.

1. Pregnancy may be prevented. Simple cysts, cystadenomata, and dermoids rarely if ever cause sterility except indirectly in that their presence may lead to surgery and resulting adhesions closing the tubes. But endometriosis, which has been most frequently found to exist in women of the late thirties and forties, is very likely to effect tubal obstruction.

2. Interruption of pregnancy may be stimulated. Early abortion is the more frequent but abortion in the middle trimester is possible, as shown by one of the case studies to follow.

3. Complication of labor may result from the presence of undiagnosed or untreated ovarian growths. The enlarged ovary may, of course, be well up out of the pelvis and in no position to cause trouble. But the tumor may be deep in the pelvis below the presenting fetal part and obstruction of labor or crushing injury to the tumor with possible peritonitis will result.

4. There may be torsion of the pedicle and strangulation of the ovary. The weight of an adenomatous cyst or dermoid may angulate and twist the pedicle as the rising uterus lifts the adnexae from the pelvis.

The incidence of all tumors complicating pregnancy is generally regarded to be about one per cent. As fibromyomata make up the great majority of these it may be said that one instance of sizable ovarian cystoma in 1500 to 2000 cases is the reasonable expectation. The occurrence of three of the four cases herewith reported in a series of 400 private obstetrical

patients is attributable to chance and is not important. It may be, however, that the increasing number of women who marry in the late thirties and the number who become pregnant only after endocrine or other treatment for infertility will bring in the future a larger percentage of cases complicated by ovarian pathology.

Diagnosis of an ovarian tumor should be relatively easy upon physical examination. Care must be observed, of course, to have each patient empty the bladder and bowel before bimanual examination. Women who are obese or exceptionally sensitive present special difficulties in examination. All patients with suspected pelvic abnormality should be reexamined after one or two weeks before advice is given. X-ray examination may contribute valuable information in the presence of dermoids. In the early stage at which most women suspecting pregnancy now present themselves differential diagnosis between a small dermoid or epithelial cyst and a luteal cyst may be difficult. With the follicle or luteal cyst spontaneous disappearance may be expected. Sudden rupture at time of examination or gradual shrinking is more likely. A period of observation is indicated. With vaginal bleeding present ectopic pregnancy must also be differentiated but the tenderness present in this condition is usually characteristic. A parovarian cyst cannot, I believe, be diagnosed in distinction from an ovarian cystoma. The parovarian swelling, being enclosed between the broad ligament layers, is almost immobile. This is important because, while less subject to torsion and strangulation during pregnancy, a sizable cyst will certainly cause obstruction or be severely traumatized during labor. There is little or no point, therefore, in distinction since both conditions require the same management, i.e.—removal.

Management of the patient with a known ovarian tumor must be dependent upon conditions present in the individual case. The possible developments previously sketched must be borne in mind with realization that the probability of torsion of the pedicle, particularly, is greater in the pregnant than in the nonpregnant case. With definite ovarian tumors, there-

fore, operative interference is almost always desirable in contrast with fibroids complicating pregnancy where interference is very seldom justified. The difficult question is whether to operate—

1. In first trimester;
2. In fourth or fifth month;
3. After the fetus is viable but before term;
4. At term: Cesarean and oophorectomy.

Desire to conserve corpus luteum function, since the luteal body may be in the abnormal ovary, urges postponement until the fourth month, when placental development is well advanced. In the fourth month, too, the irritability of the uterus is least apparent and conditions for operation are most favorable generally. Time for laparotomy wound healing before labor is adequate and it would seem that this is the most satisfactory time for surgical intervention. One author advises operation in the seventh month so that the baby will have a good chance for survival if labor is initiated. To my mind, the necessary hospitalization and convalescence with its dislocation of the entire prenatal program and the disadvantage of wound healing with the abdomen increasingly distended makes this undesirable.

Cesarean operation and ovariectomy at term is a satisfactory procedure for the cases of late or uncertain diagnosis where obstruction of labor is definite or potential. Interference is not usually necessary when a non-obstructing ovarian tumor comes to attention late in pregnancy.

Concerning operative management, it seems desirable to mention that spinal anaesthesia or avertin-nitrous oxide anaesthesia provide ideal conditions for operating with a minimum of disturbance to the uterus and other abdominal organs. The use of adequate pre-operative sedation contributes a great deal to smooth anaesthesia and recovery. Before spinal puncture particularly, morphine and scopolamine should be given in small doses every two hours until stupor is effected.

Subsequent to operation opiates should be given freely for forty-eight hours. Codeine and phenobarbital may then be well tolerated by mouth and should be administered for several days to lessen the chance of abortion.



#### CASE I.

Mrs. I. H.; age 28, grav. IV, para 1.

Torsion of cystadenoma. Emergency operation.  
Pregnancy uninterrupted.

Two spontaneous abortions preceding term pregnancy.

Child of three living and well after uncomplicated labor and puerperium.

This fourth pregnancy of eight weeks' duration was unevenful and no medical attention had been sought until severe right lower quadrant pain seized the patient after she rose from bed in the early morning. Morphine by hypodermic partially relieved the pain but soreness and discomfort continued until at operation 24 hours later a strangulated, partially gangrenous papillary cystadenoma of the right ovary was removed. Pregnancy was not interrupted and a normal infant was delivered at term.

#### CASE II.

Mrs. E. K.; age 26, grav. II.

Pseudomucinous cystadenoma apparently causing abortion. Successful removal early in second pregnancy.

In first pregnancy the patient reported in the twelfth week with signs of inevitable abortion. Two days later under N<sub>2</sub>O-O anaesthesia examination preceding curettage showed a soft cystic mass in right adnexal region. Office examination after six weeks showed the mass to be persistent. The size and character of the tumor were such that operative removal was advised but was refused. Four months later in the sixth week of second pregnancy, right oophorectomy and appendectomy were performed under spinal anaesthesia. The site of corpus luteum was not determined at time of operation. The pathological report showed the cyst to be a pseudomucinous cystadenoma. The course of pregnancy proceeded normally, resulting in the satisfactory delivery of twins near term.

#### CASE III.

Mrs. J. F.; age 25, grav. II.

Pregnancy at term. Dermoid obstructing pelvis.  
Cesarean and ovariectomy.

This woman also presented herself with abnormal bleeding in the third month of pregnancy making thorough examination in the office impossible. With the onset of severe cramps and profuse hemorrhage the patient was hospitalized. Examination under pentothal intravenous anaesthesia preliminary to curettage revealed the presence of a firm, rounded mass in the pelvis behind and to the left of the cervix. Four weeks later reexamination in my office failed to show any pelvic pathology—an error which may be in part explained by the unusual size (6 ft. height and 200 lb. weight) of the individual.

A second pregnancy initiated within four months

progressed without event. Two weeks before term vaginal examination revealed a firm globular tumor, the size of a large orange, in the cul-de-sac compressing the vagina and cervix forward and obviously obstructing the pelvic passage. X-ray examination showed shadows typical of teeth in the mass and made the diagnosis of a dermoid. At the time of expected confinement low-flap Cesarean and left salpingo-oophorectomy was performed under spinal anaesthesia. A seven-pound twelve-ounce male child was delivered. Post-operative progress was entirely uneventful and the patient left the hospital on the thirteenth day.

#### CASE IV.

Mrs. L. S.; age 26.

Large dermoid cyst obstructing pelvis and confusing diagnosis of 16 weeks' pregnancy. Operative removal. Pregnancy uninterrupted.

Of the four cases reported this woman alone had an unusual menstrual history. One year previously amenorrhoea for three months was noted and intervals of five to six weeks between menses had been frequently observed. The patient's physical habitus was not suggestive of endocrine fault. Two years of marriage had failed to bring a wished-for pregnancy, but no work-up for infertility had been sought. One examination at time of the omission of menstruation for three months resulted in a diagnosis of a "tumor".

At first examination by me this young woman told of four months' amenorrhoea with no symptoms suggestive of pregnancy. The lower abdomen was markedly distended by a mass of irregular rounded contour which also filled the right flank. The cervix could not be well palpated because it was crowded high and forward close to the pubic arch by a firm but fluctuant mass in the pelvis pressing forward from the cul-de-sac. Although colostrum was present in the breasts a tentative diagnosis of bilateral ovarian cystoma was made. The occurrence of vaginal bleeding typical of menstruation in character and duration apparently confirmed this impression.

At operation a large unilateral tumor arising in the right ovary was found to fill the pelvis—extending then upward behind and to the left of the enlarged soft uterus which was crowded into the right flank. It was necessary to bring the uterus forward into the laparotomy wound to deliver the tumor from behind it and from its position deep in the pelvis.

The tumor approximated a football in size and proved on section to be a dermoid.

The anaesthesia in this case was avertin gas oxygen. Morphine was given freely for two days after operation and then codeine and phenobarbital for the remainder of a week.

Pregnancy was not interrupted and five months later (September 22, 1941) a living female infant was born by spontaneous delivery.

## EXECUTIVE OFFICER'S PAGE

### COMMITTEE MEETINGS

#### I.

The success of a committee meeting is largely dependent upon the Chairman, who, as the leader, takes the initiative in calling meetings and arranging the agenda. The Medical Society Executive Staff will assist Committee Chairmen in arranging details. The Committee Chairman can, in this way, insure the best use of time and materials needed for each meeting.

Committee members should be chosen primarily because of their established interest and proven ability in the field assigned to the committee. Committee members should each in turn enlist the interest, support and participation of the members in their County Societies.

Each committee should have a secretary whose responsibility should be to record the subjects discussed at each meeting, the decisions reached and the recommendations made, and forward these to the Executive Offices for transmission to the proper authorities. This is extremely important. Copies of the minutes of each meeting should be promptly mailed to the Executive Office and a copy kept by the Secretary of the Committee. Only in this way can new members of a committee be made aware of the foregoing actions of the committee and participate knowingly in the work of the committee.

The Chairman, though the most important member of the committee, should be the least conspicuous and should take as little time and part in the discussions as possible, so as to give each member a full opportunity to present his contribution to the considerations of the committee as a whole. It is the committee members, whose pooled contribution constitutes the information made available to the Chairman and the Secretary, out of which the report to the Executive Office and the Officers of the Society is made.

While no pertinent part of the discussion of any member should be stifled, strict control of irrelevant discussion in the meetings is essential in fairness to those who stick to the subject under discussion. This control is the responsibility of the Chairman. He should dispatch the meeting according to the time schedule prepared so that the time shall be spent most productively, and so that the members of the committee shall know how to schedule the rest of their day's work. This means that

the meetings shall begin and end at the time stated by the Chairman. The Chairman should be aware of those, who at any given meeting, are not participating and diplomatically refer to a point under consideration, asking their opinion.

When points of debate arise it is diplomatic for the Chairman to assign definite time limit for each speaker (three minutes is the usual time allowed for an individual contribution, but this can be extended for a particular case) by a majority vote.

The Chairman should also clearly restate to the group the point at issue so as to avoid irrelevancy in the discussion.

Any member of the committee may pose a question that is relevant to the subject under discussion, and the Chairman, rather than answer the question himself, should refer it to one or more members of his committee. After adequate discussion has been held he can summarize the majority opinion.

Studies are conducted on the attendance at committee meetings, and they reveal the fact that attendance is largely determined by the *opportunity for participation*, provided by the Chairman, for the members. The accomplishments shown by committees usually correlates highly with the degree of participation by the members. It is better for all members to have an opportunity to participate, even though they decline the opportunity, as they properly should if they feel they do not have a real contribution to make. The Chairman should have unquestioned control of the meeting at all times, even though he himself participates little. His ability to condense and clarify subject matter marks him as a leader. This ability is inherent in certain people and absent in others. Those who do not have it should be retained as a member of the committee rather than as chairman. Business organizations everywhere recognize and emphasize the importance of a good chairman. Relatively few physicians have had sufficient opportunity and experience as group leaders, though there are many brilliant exceptions to this statement among our members, as is shown by the fact that the same men are repeatedly used by the Society when they are discovered. This is a real need and will be further increased as group services on an organized basis become increasingly a function of The Medical Society.

## LEGISLATIVE NEWS

### THE SOCIAL SECURITY ACT AMENDMENTS OF 1942

#### AN ANALYSIS OF THE PROVISIONS OF H. R. 7534 OF INTEREST TO THE MEDICAL PROFESSION, A BILL INTRODUCED BY REPRESENTATIVE

ELIOT, MASSACHUSETTS, SEPTEMBER 9, 1942

Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, Chicago,  
September 15, 1942.

*In General.*—This bill, to be cited as the Social Security Act Amendments of 1942, proposes to amend and extend the provisions of the Social Security Act by establishing a Federal Social Insurance System. This System will be financed from a Federal Social Insurance Trust Fund consisting of the securities held by the Secretary of the Treasury for Federal Old-Age and Survivors Insurance Trust Fund (already established under existing law) together with funds to be made available by means of the contributions provided for in the bill. This trust fund will be managed by a Board of Trustees composed of the Secretary of the Treasury, the Secretary of Labor and the Chairman of the Social Security Board, all ex-officio. Separate accounts within the trust fund may be established as the Board of Trustees deems necessary or desirable.

*Contributions to the Trust Fund.*—Employers coming within the provisions of the bill, except as noted below, will be required to make "social insurance contributions" equal to the following percentages of wages paid by them after December 31, 1942: with respect to wages paid during the calendar years 1943, 1944, and 1945, the rate will be 5 per cent; for 1946, 1947, and 1948, the rate will be 5.5 per cent; and thereafter the rate will be 6 per cent. Employees will be required to make contributions equal to the same percentages of wages received. The term "wages" does not include that part of the remuneration which, after remuneration equal to \$3,000 has been paid to an individual with respect to employment during any calendar year after December 31, 1942, is paid to such individual with respect to employment during such calendar year. The bill also excludes from the meaning of the term "wages" certain other payments made by employers.

Every self-employed individual will make a social insurance contribution equal to the following percentages of the market value of his services rendered as a self-employed individual, after December 31, 1942, with respect to services in self-employment after such date, not including that part of any remuneration for employment and the market value of services in self-employment in excess of \$3,000

for any calendar year; for the calendar years 1943, 1944, and 1945, the rate will be 4 per cent; for the calendar years 1946, 1947, and 1948, the rate will be 5 per cent; and thereafter the rate will be 6 per cent.

Services performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, now exempt from the operation of the Social Security Act, will be brought within the provisions of the act by the pending bill. Employers in such employments will be required to make social insurance contributions as follows: with respect to wages paid during the calendar years 1943, 1944, and 1945, the rate will be 2 per cent; for 1946, 1947, and 1948, the rate will be 2.5 per cent; and thereafter the rate will be 3 per cent. Employees in such employments will be required to make contributions at a similar percentage of wages received.

*Federal Old-Age, Survivors, and Disability Insurance Benefits.*—Existing provisions of the Social Security Act providing for Federal old-age and survivors benefits are amended in numerous respects and, in addition, there is added a provision under which disability benefits will be paid. The term "disability" is defined to mean total and permanent disability to work by reason of illness or injury. An individual is to be considered totally and permanently unable to work when he is afflicted with any impairment which continually renders it impossible for him to engage in any substantially gainful work and which is founded on conditions which render it reasonably certain that it will continue to be impossible to do so throughout the remainder of his life. No individual is to be deemed under disability for any period prior to the sixth month before the month in which he filed application for disability benefits.

In addition to cash disability benefits, the bill will authorize the Social Security Board to "make provisions" for furnishing of medical, surgical, institutional, rehabilitation, or other services to individuals entitled to the cash disability benefits, if such services may aid in enabling the individuals to return to gainful



work. Such services, the bill provides, shall be furnished by "qualified practitioners" and through governmental and nongovernmental hospitals and other institutions qualified to furnish such services. The construction of hospitals or other institutions is not authorized. Expenditures for these services may not, during the period January 1, 1944, to June 30, 1945, exceed \$400,000. Thereafter, expenditures may not exceed 2 per cent of the total amount expended during the preceding fiscal year for the payment of disability benefits.

This portion of the bill also brings within the Federal Old-Age, Survivors, and Disability Insurance Benefits provisions self-employed individuals and certain employments not included under the existing law, such as services performed in the employ of corporations and associations organized for scientific, charitable, and educational purposes.

*Federal Unemployment Insurance and Temporary Disability Benefits.*—This section proposes to federalize unemployment insurance and temporary disability benefits. Grants that are being made at the present time to States for unemployment compensation will cease after the fiscal year ending June 30, 1944, and the program proposed by this section will become effective. Unemployment benefits, under a schedule set out in the bill, will be paid to the individual by the Federal Government out of the Federal Social Insurance Trust Fund.

Cash benefits are proposed also when an individual by reason of illness or injury is temporarily totally unable to work at his "last, accustomed, or reasonably similar occupation", as may be determined by the Board. To entitle an individual to disability benefits, he must be "certified as disabled", in accordance with such regulations as the Board may prescribe and he must have been continuously disabled for a waiting period of one week immediately prior to any week with respect to which disability is claimed.

In addition to disability benefits otherwise payable, the bill provides a weekly maternity benefit, to be paid in cash, for a period of not more than twelve consecutive weeks, commencing not earlier than six weeks prior to the week in which confinement is expected and terminating not later than six weeks subsequent to confinement. A woman, otherwise eligible for disability benefits, may obtain the maternity benefit if she has during the twenty-six consecutive-week period immediately preceding the week in which her confinement is expected to occur complied with such regulations with respect to prenatal care as may be prescribed by the Social Security Board, and if she has during the confinement and during

each week subsequent thereto with respect to which she claims the maternity benefits, complied with such rules and regulations as may be prescribed.

Each individual claiming or receiving disability benefits or maternity benefits, if requested by the Board or its duly authorized representatives, must submit to an examination by such physician or expert as the Board may designate at such reasonable time and place as the Board or its representative may direct, and any failure or refusal, without good cause, to submit to such examination or an obstruction therefor will result in a forfeiture of such individual's right to such benefits until such examination has taken place.

To aid in carrying out the provisions of this particular section of the bill, the Social Security Board will be required to establish a Federal Advisory Council or Councils composed of men and women representing employers and employees in equal numbers and the public for the purpose of formulating policies and discussing problems related to unemployment, employment, and disability and insuring impartiality, neutrality, and freedom from political influence in the solution of such problems.

*Federal Hospitalization Benefits.*—The hospitalization benefits proposed by this bill will be available to the employed individual and to the wife and dependent children of such individual, provided the employed individual had during a prescribed preceding period been paid wages for employment equal to not less than a stated amount. The term "hospital benefits" is defined to mean an amount not less than \$3 nor more than \$6, as determined by the Social Security Board after consultation with the National Advisory Hospital Benefits Council to be created by the bill, for each day of hospitalization. In lieu of such compensation, the Board may make arrangements with accredited hospitals for the payment of the reasonable cost of hospital service. Such benefits are not available with respect to any individual whose period of hospitalization was due to an injury or disability arising out of or in the course of any employment, nor, apparently, to self-employed individuals, nor with respect to any day of hospitalization for tuberculosis or for mental or nervous diseases after such diagnosis has been made.

The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefits will be thirty. If, however, the Board of Trustees finds that a separate account for Federal Hospitalization Benefits in the Federal Social Insurance Trust Fund is adequate, the Board may increase the

maximum to not more than sixty days in the following calendar year.

Hospitalization must be in an accredited hospital to entitle an individual to the proposed benefits and the Social Security Board on or before January 1, 1944, must publish a list of institutions found by it to be accredited hospitals. An accredited hospital is defined to mean "an institution providing, at least, bed and board, general nursing care, the use of an operating or of a delivery room, ordinary medications and dressings, laboratory and x-ray services, and other customary hospital care and services, and found by the Board to afford professional service, personnel, and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institution and to have procedures for the making of such reports and certifications as the Board may from time to time require, to assure that payment of hospitalization compensation will be made only to individuals entitled thereto". The term accredited hospital does not include institutions found by the Board to be chiefly devoted to the care of persons afflicted with nervous or mental diseases, tuberculosis, or other chronic illnesses. The Board may accredit a hospital "for limited varieties of cases" and in determining the adequacy of the professional service, personnel, and equipment of any institution may take into account the type and size of community which the institution serves, the availability of other hospital facilities and other relevant matters.

The bill establishes a National Advisory Hospital Benefits Council to be composed of members appointed by the Social Security Board and selected by it from the professions and agencies concerned with the operation of hospitals, and other persons informed on the need for or provision of hospital services. This Council is to be authorized "to advise" the Board with reference to (1) the formulation of standards for accrediting hospitals; (2) the establishment and maintenance of the list

of accredited hospitals; (3) the conduct of studies and surveys of the quality of hospitalization services furnished by hospitals; (4) the establishment of special advisory, technical, local or regional committees or commissions; and (5) with reference to such other related matters as in the opinion of the Board may aid it in the administration of the hospitalization benefits program.

The Social Security Board will be authorized, through agreements or coöperative working arrangements with appropriate agencies of the United States, or of any State or political subdivisions thereof, and with other appropriate public agencies and private persons, agencies or institutions, to utilize their services and facilities. Any person entitled to a hospitalization benefit may transfer or assign such benefit to an accredited hospital or to any other agency or institution utilized by the Social Security Board.

The Social Security Board will, from time to time, certify to the Secretary of the Treasury the name and address of each individual entitled to hospitalization benefits and the amounts of such payments. Payment may be made directly to the individual entitled to the benefits or to such other individual, agency, or institution as the Board may prescribe, or if the Board so directs, payments will be transmitted to the Board for distribution in such manner as it may prescribe.

*Individuals in Military Service.*—This bill contains provisions under which the rights of individuals in service to old age and survivors insurance benefits will be safeguarded and under which unemployment compensation allowances may be granted on termination of military service under conditions set forth in detail in the measure.

*Status of Bill.*—H. R. 7534 is pending in the House Committee on Ways and Means, of which Representative Doughton, of North Carolina, is Chairman.

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## VOCATIONAL REHABILITATION

A bill is now pending to provide for vocational rehabilitation of individuals suffering from war-connected or other disabilities. This bill is divided into three titles. The first title proposes to provide for *war-disabled* persons a vocational rehabilitation program. Title 2 would provide a vocational rehabilitation program for *persons disabled in industry or otherwise*, so that they might return to civil employment. This act is designated as a Coöperative

Rehabilitation Training Act. Title 3 proposes an enactment of a vocational rehabilitation act for the *blind*.

In the bill these terms are still more specifically defined. *Vocational rehabilitation* means the rendering of a disabled individual fit to engage in a remunerative occupation and his placement in employment, including where needed, physical restoration or repair, medical examination and care, prosthetic and other de-

vices, physical and occupational therapy, training, placement in employment, and other appropriate services.

*Rehabilitation training* means any training given to render a disabled person fit for employment.

The term *disabled individual* means any individual who has attained the age of sixteen years and who by reason of a physical defect or infirmity, whether congenital or acquired by accident, injury, or disease, is, or may be expected to be, totally or partially incapacitated for remunerative occupation.

A *war-disabled individual* is defined to mean a disabled individual whose disability proximately resulted from a personal injury or disease incurred while he was a member of the armed forces of the United States or the Army of the Philippines, or whose disability proximately resulted from a war injury.

The term *war injury* is defined as a personal injury sustained after December 6, 1941, proximately resulting from a war-risk hazard and includes any disease proximately resulting from such a personal injury. In the case of a civilian defense worker, the term also includes a personal injury sustained by such worker after December 6, 1941, while in the performance of his duty as such worker, or disease incurred by him which was proximately caused by his performance of such duty after such date. In the case of a civilian detained by the enemy whose detention commenced after December 6, 1941, the term *war injury* also includes a personal injury or disease resulting from such detention.

The term *war risk hazard* is defined to mean any hazard arising after December 6, 1941, and prior to the end of the present war, from:

1. The discharge of any missile (including liquids and gas) or the use of any weapon, explosive, or other noxious thing by an enemy or in combatting an attack or an imagined attack by an enemy; or

2. Action of the enemy, including rebellion or insurrection against the United States or any of its Allies; or

3. The discharge or explosion of munitions intended for use in connection with the national war effort, except with respect to an employee of a manufacturer or processor of

munitions during the manufacture or processing thereof, or while stored on the premises of the manufacturer or processor; or

4. The collision of vessels in convoy or the operation of vessels or aircraft without running lights or without other customary peacetime aids to navigation; or

5. The operation of vessels or aircraft in a zone of hostilities or engaged in war activities.

The term *civilian defense worker* is defined to mean any civilian who is engaged in the Aircraft Warning Service, or is a member of the Civil Air Patrol, or is a member of the United States Citizens Defense Corps in the protective services engaged in civilian defense, as such protective services are established from time to time by regulation or order of the Director of the Office of Civilian Defense, or is registered for a course of training prescribed and approved by the Director for such protective services. Persons who are paid by the United States, or any department, agency, or instrumentality thereof, for services as civilian defense workers are *excluded* from the definition.

To the extent that the Administrator of the Federal Security Agency finds necessary in any State because of the inadequacy or unavailability of services and facilities for rehabilitation training, he may provide the services and facilities. He will be authorized to utilize the available facilities and services of units of the Federal Security Agency to the extent feasible and may utilize the available facilities and services of other federal departments and agencies. He may enter into agreements or co-operative working arrangements with public agencies and private persons, agencies, or institutions within the United States, its territories and possessions, to utilize their services and facilities and to compensate them for such use.

Vocational rehabilitation under this title will be carried on, apparently, at the expense of the Federal Government and under its direction.

The financing of these proposals will be through matched funds and is described at length in the bill, as are the qualifications for blind persons who seek relief under this legislation.

## MEDICAL AND HOSPITALIZATION BENEFITS FOR VETERANS OF WORLD WAR II

A bill introduced by Senator Clark of Missouri is in the Finance Committee of the Senate. The purpose of this bill is to accord to

the veterans of the present war the medical and hospitalization benefits made available to veterans of World War I.



## TIMELY TOPICS

### HEATING AND HEALTH

The Journal of the American Medical Association in a recent issue abstracts a report submitted to the Advisory Committee, Fuel Rationing Division, U. S. Office of Price Administration, by a subcommittee headed by Leverett D. Bristol, M.D., Dr. P.H., New York. The subject of heating is discussed in the light of the need for fuel economizing, necessitated by the war. A suggested slogan based on a popular song of the first World War is "Keep the Home Fires Buring—Low!"

It is pointed out that physicians, engineers and public health workers have been accustomed to think of indoor heating and ventilation in terms of a "comfort" zone. Because of the war and shortage of fuel, we may have to reorganize peacetime procedures in the direction of a "discomfort" zone. Health should not be jeopardized; any rationing plan adopted should be based on equality for all, with special consideration for those of tender or advanced age, or those with actual disease or lowered vitality.

It is undoubtedly true that in the past we have erred on the side of too high temperatures and too dry atmospheres. Temperatures must be kept down, but we must not err at the other extreme so that severe chilling and possible sickness may result. While most of our winter ills are due to bacterial and virus infections, scientific evidence shows the important relationship of lowered resistance and changes of weather to these conditions. There is little experimental evidence to show what an individual in a wartime economy can get along without in his artificial heat requirements without injury to health.

#### TEMPERATURE NEEDS—REGULATION

An ideal temperature without regard to humidity and air motion does not exist, nor is there any definite safe minimum temperature without these influencing factors. The following table listed in the abstract sets forth summaries of opinions as to minimum temperatures for various types of living quarters in the light of emergency requirements of fuel oil rationing:

- a. For the average private home, 60°-68° F. (majority opinion 65° F.)
- b. For the average apartment house, 60°-68° F. (majority opinion 65° F.)
- c. For hospitals and sanatoriums, 68°-80° F. (majority opinion 70° F. except operating rooms 80° F.)

- d. For schools, 60°-70° F. (majority opinion 65° F.)
- e. For department stores, office buildings, and so on, 60°-68° F. (majority opinion 65° F.)

The list is qualified by a notation that the majority opinions given are subject to local regulations or codes. In Connecticut, Section 2659 of the General Statutes calls for a minimum temperature of 68° F. in leased buildings used as residences, offices or places of business where heat is furnished by the lessor directly or through an agent.

The report stresses especially the temperature needs of certain groups of individuals. It is stated that where there are children under four years of age, a temperature of not less than 70° F. should be provided and this temperature would also take care of the needs of the nursing mother. After the fourth birthday, normal children need a cooler and not a warmer environment than adults. Older people, particularly those of lowered vitality, should have a temperature of not less than 70° and possibly as much as 74°. Consideration should be given to individual differences; some people are "old" at 55, others are "young" at 70. The report suggests the need for coöperative program in allotting fuel supplies to care for special cases such as those mentioned. Where there are cases of acute or chronic illness or invalidism, the physician is the best adviser of the need.

#### HOW YOU CAN HELP

Thermostats should be properly adjusted and reconditioned and should be subject to the supervision and manipulation of one rather than several persons. Simple daily records of indoor temperatures are advised so as to cut down on wastage. Much publicity has already been given to the desirability of conversion of heating facilities from oil to coal where practicable because of the difficulties in securing sufficient supplies of oil. The use of insulating materials, weather stripping and provision of storm windows all have been recommended to cut down heat losses.

The report suggests that little or no attempt should be made to heat bedrooms, except those occupied by infants, aged persons or those who are ill. Bedroom temperature may be from 50° to 60° F. It is recommended that the bathroom be kept warm; plans may be made for using the bathroom or some other adequately heated quarters for dressing and undressing.

Warm night clothes and bed coverings should be provided. The temperatures of living rooms are of more importance than temperatures of dining rooms, halls and kitchens, unless these other rooms are really occupied as living rooms. Many home owners are planning to utilize fireplaces as additional sources of heat. Fireplace vents should be closed off when not in use. Drafts from windows, doors and fireplaces should be minimized by keeping windows and doors closed. Pulling down window shades at night helps to prevent drafts. Indoor

comfort and health depend on individual adjustments of clothing as much as on proper heating and ventilation. Double comfort standards between men and women are due largely to differences in dress or clothing. Every individual should realize the importance of giving consideration to adequate amounts of clothing, and a heavier dress or suit, an extra undergarment or overgarment may do much toward winter health and comfort in "overcool" rooms. The report suggests "Wear a sweater and help win the war!"

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## FACTS CONCERNING THE WORK OF THE MUNICIPAL AID ADMINISTRATION

The August report of the Municipal Aid Administration Director, Mr. Charles R. Erdman, Jr., shows a marked decline in the number of persons receiving relief, the number of cases carried on its rolls and the financial commitments made for relief purposes. These general trends show a marked drop within the last year, practically cutting in half the load and cost, and are most encouraging and show an alertness on the part of the Municipal Aid Administration in adjusting its assistance to the need in New Jersey. The report gives the actual figures on average case costs, employables and non-employables, dependency, unemployment compensation and similar interesting items. Figures for each county are given, and the percentage of each in commitments is indicated. This is an interesting report and infor-

mative to those who will take the trouble to study it carefully.

From such studies also come interesting sidelights arising out of the discussion held by the Administration and the Welfare Agency representatives. One of these is the relationship of inadequate housing to juvenile delinquency. "If there is no place at home for children to bring their friends, and if living quarters are crowded even for members of the family, the youngsters are literally forced to spend their leisure time in the streets and taverns and skating rinks."

The school lunch program is to be substantially larger than a year ago. It is hoped that 1,500,000 more children will be reached than the 5,100,000 a month who were cared for under this program in 1941-1942.

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## CHILDREN'S FEET

A reprint from an article by Dr. Fremont A. Chandler, appearing in the June, 1942, issue of the American Journal of Disease of Children, deals with a subject too often ignored by many persons in the medical profession. Pediatricians have in the last few years increasingly become aware that children's feet need scientific consideration so that parents may be properly advised and not have to rely upon the advice given by commercial concerns not always scientifically based and having as their purpose primarily the sale of shoes and other devices.

Dr. Chandler points out that the "foot should never be considered as a detached segment of the body. In structure, growth and function it reflects the whole organism. It is heir to every developmental, nutritional and functional disturbance found elsewhere in the host."

The author points out that the treatment of club foot should begin early with manipulation and the skilful application of plaster casts. The three functions of a normal foot are the grasping or prehensile function so evident in early life, the muscular coördination necessary to the change from the second or static function of the foot into the third, or propulsion function. He further analyzes the three component parts of the normal stride in a heel and toe gait as extension, support and propulsion, and illustrates these functions so that the understanding is made easy.

Here is a subject upon which too many of us as physicians are not adequately prepared, and it is one on which more attention and effort should be concentrated by general practitioners of medicine. The pediatricians are for-

tunately taking a lead from the orthopedists in appreciation of this important subject. This may be due, as Dr. Chandler suggests, to the fact that orthopedics and pediatrics etiologi-

cally come from the same Greek word. It is fortunate for children and their parents that a wider spread interest in this subject is making its appearance.

## POST-GRADUATE INDUSTRIAL MEDICINE

A development of timely interest in post-graduate industrial medicine courses is the month's "internship" in the medical departments of industrial establishments which the Long Island College of Medicine in Brooklyn, N. Y., has arranged following the two-week course of lectures and clinics from November 2 to November 13.

Plans have been completed to provide opportunities for additional supervised training in the medical departments of eleven selected industrial organizations between November 16 and December 12. Physicians electing to serve these "internships" may thus obtain experience according to their interests and preferences. They will also better prepare themselves to accept the numerous positions awaiting trained doctors in the industrial field.

The first "internship" appointments are being made and it is expected that by the time the course begins on November 2 all applicants who can be placed under wartime conditions will have received appointments for their month of practical work in industrial medical departments.

The companies which have offered to accept one or more "interns" for training are: American Cyanamid Company, Calco Chemical Division, Bound Brook, N. J.; American Telephone and Telegraph Company, New York City; Bell Laboratories, New York City; Brooklyn Union Gas Company, Brooklyn, N. Y.; Consolidated Edison Company, New York City; Corn Products Refining Company, Argo, Ill.; Dow Chemical Company, Midland, Mich.; Merck & Co., Inc., Rahway, N. J.; New Departure Division, General Motors Corporation, Bristol, Conn.; New York Telephone Company, New York City; Republic Aviation Corporation, Farmingdale, Long Island.

Applications have been received from physicians in New York State, Massachusetts, New Jersey and Pennsylvania. Up to mid-October applications were about evenly divided between physicians with and physicians without industrial connections. Physicians in the latter group are applying for "internship" appointments.

The College has followed the standards established by the American College of Surgeons

for approved industrial medical departments in selecting firms for "internships".

Typical of the kind of "internship" training which will be provided is the program set up by Dr. John J. Wittmer, medical and personnel director of Consolidated Edison Company. Dr. Wittmer is co-chairman with Dr. Cassius H. Watson, medical director of American Telephone and Telegraph Company, of the Advisory Committee of Industrial Physicians and experts established to give the College counsel on the planning of this course, which is the first it has offered in this field. Both Dr. Wittmer and Dr. Watson are alumni of the College.

The Consolidated Edison plan provides for the "intern" to take his month's training in one or more of the eleven dispensaries of the company in greater New York. Some of the work will be done in the company's central medical department. The program for the month is as follows:

### FIRST WEEK

Monday—Medical Clinics.  
Tuesday—Surgical and Accident Treatment Clinics.  
Wednesday—Surgical and Accident Treatment Clinics.  
Thursday—Industrial Nursing Procedures.  
Friday—Medical Record Keeping.

### SECOND WEEK

Monday—Eye Specialist.  
Tuesday—E. N. T. Specialist.  
Wednesday—Diagnostic Specialist.  
Thursday—Physiotherapy Service.  
Friday—Dermatological Specialist.

### THIRD WEEK

Monday—Industrial Accident Case Supervision.  
Tuesday—Medical Administration.  
Wednesday—Medical Administration.  
Thursday—First Aid Station Inspection—Plant Hygiene Survey.  
Friday—Layout and Furniture of Medical Bureau.

### FOURTH WEEK

Monday—Absenteeism Control.  
Tuesday—Medical Statistics.  
Wednesday—Coöperation with Safety Engineer—Resuscitation Instruction.  
Thursday—Compensation Law.  
Friday—Medical Clerical Procedures.



## STATE ACTIVITIES

### NOTE: CHANGE OF ADDRESS

The new address of the Executive and Editorial Offices of The Medical Society of New Jersey is 222 West State Street in Trenton. The telephone number is Trenton 5776.

The new offices are conveniently located, attractive and well arranged. The Board Room is dignified in appearance and well suited for the purpose of the Trustees. The building is impressive in appearance and consistent with a professional society's headquarters. Mem-

bers are invited to visit the offices any time they are in Trenton.

Economy was the primary reason for moving to the new offices, but the new location is admirably suited to the Society's needs. The staff has been reduced by the resignation of two girls who found better positions and who will not be replaced immediately in view of the curtailed activities which have been approved for the duration.

### SUPREME COURT TO REVIEW QUESTIONS RELATED TO PRACTICE OF MEDICINE

Questions related to the practice of medicine will be reviewed by the Supreme Court of the United States, *The Journal of the American Medical Association* for October 24 says in an editorial explaining the events leading up to the recent announcement of the court. *The Journal* says:

"An indictment was filed on December 20, 1938, in Washington, D. C., which charged the American Medical Association, the Medical Society of the District of Columbia, two other medical societies, certain officers of the medical societies and others with conspiring to restrain the trade of Group Health Association, a corporation, in violation of section 3 of the Sherman Act. The District Court first held that the indictment did not charge the defendants with any offense known to the law, but the Court of Appeals of the District of Columbia reversed this holding and directed a trial of the case. In due course a trial was held and the jury found the American Medical Association and the Medical Society of the District of Columbia guilty and all of the other defendants not guilty.

"On May 29, 1941, the District Court entered judgment on the verdict of the jury. An appeal was taken to the Court of Appeals of the District of Columbia, and that court on June 15, 1942, affirmed the judgment of the lower court. The American Medical Association and the Medical Society of the District of Columbia filed a petition in the Supreme Court of the United States asking that court to issue its writs of certiorari to review the decision of the Court of Appeals and to reverse it and to hold that there had been no violation of section 3 of the Sherman Act.

By their petition for certiorari filed in the Supreme Court of the United States, the American Medical Association and the Medical Society of the District of Columbia contended that there were eight important questions presented by the record in the case wherein the trial court and the Court of Appeals committed error.

"On October 12, 1942, the Supreme Court of the United States granted the petition for writs of certiorari and thereby agreed to review and consider the record in the case but limited the review to the consideration of the first three questions presented by the petition for writs of certiorari, which were:

1. Whether the practice of medicine and the rendering of medical services as described in the indictment are "trade" under section 3 of the Sherman Act.
2. Whether the indictment charged or the evidence proved "restraints of trade" under section 3 of the Sherman Act.
3. Whether a dispute concerning terms and conditions of employment under the Clayton and Norris-LaGuardia acts was involved, and, if so, whether petitioners were interested therein, and therefore immune from prosecution under the Sherman Act.

"The American Medical Association and the Medical Society of the District of Columbia will now file their printed brief and argument in the Supreme Court of the United States and thereafter the case will be argued orally and the court will then consider the three questions which it has consented to review and in due course file its decision and opinion."—*A. M. A. News*.

## MEDICAL CARE FOR WIVES AND CHILDREN OF ENLISTED MEN

The Medical Society through its representatives has agreed to participate in an experiment which has three advantages worthy of thoughtful consideration and experimentation.

First, it provides a plan which will aid in the war by relieving the minds of enlisted men of worry concerning their dependents who may need medical attention. When the dependents are unable to pay for it themselves the government will do so.

Second, this is part of the larger problem of indigent care with which the profession is eternally faced and for which we have not found as yet a satisfactory solution.

Third, the government will pay the costs and the physician will benefit in prestige and financially.

The procedure is simple:

1. The patient applies for authorization for service to the authorizing agency—usually the Child Health Nurse in the community.

2. The patient presents to the physician such authorization certificate and he renders the service he finds the patient needs and mails the record to the Bureau of Maternal and Child Health, Room 430, Broad Street Bank Building, Trenton, N. J. The physician will so state if hospital care is essential.

3. Consultation will be provided upon application by the physician to and approval by the Bureau in Trenton.

This is a form of Group Service, which is one of the newer developments in medical practice insofar as the private practitioner of medicine is concerned, but one in which he is likely to increasingly participate in the future if the present trends are indicative. He should, therefore, be prepared, and this experiment offers an opportunity to learn and to assist in the evolution of this newer form of medical practice. All group-practice requires recording and reporting. Blind opposition to this essential procedure is unjustified, even though physicians often do not always appreciate the necessity for records. These have been kept at a minimum so far as the physicians are concerned.

The records shown below indicate the procedure for the *physician* to follow.

Part III (Form 12) is filled out in every case.

PART III—To be filled out by attending physician.

## MATERNITY CARE

Date of first physical examination by me during this pregnancy .....

Expected date of confinement .....  
Delivery recommended: At home ☐  
In hospital ☐  
Name of Hospital or Maternity Home recommended .....

## PEDIATRIC CARE

Date of first physical examination .....  
Probable diagnosis of medical condition.....  
Recommend care: At home ☐  
In hospital ☐  
Name of hospital recommended .....

1. If maternity care is authorized by the Bureau of Maternal and Child Health, I agree to provide, to the best of my ability, complete prenatal, delivery and postpartum medical care to this patient and care of her new-born infant, at the rates paid by the Bureau of Maternal and Child Health, without further charges to the patient or her family.

2. I also agree to accept the rates paid by the Bureau for any partial maternity service or medical care for the sick child of this family.

3. I also agree to fill out and return to the Bureau the maternity or pediatric record supplied by them.

Signature ....., M.D.

Date .....

Attending physician will mail this form to  
Bureau Maternal and Child Health, Room  
430, Broad Street Bank Bldg., Trenton,  
New Jersey.

Form 14 is used when a consultant is requested.

FORM 14—To be filled out by Attending Physician when calling a Consultant under Medical Care Plan—Paid for from Maternal and Child Health Funds. To be forwarded to Bureau of Maternal and Child Health, Room 430, Broad Street Bank Bldg., Trenton, N. J.

Name of Patient .....  
Address ..... Age.....  
Working Diagnosis .....  
Reasons for Consultation .....  
Name of Consultant Called .....  
Address of Consultant .....

(Signature of Attending Physician)

(Address of Attending Physician)

Forms to be obtained from Bureau of Maternal and Child Health.

(Form 13 is used only by the consultant in reporting to the Bureau.)

Form 15 is used for the final report on each

case. It is the evidence on which the government makes payment to the M.D. for services rendered.

FORM 15—To be filled out by Attending Physician or Hospital on Completion of Care to Sick Child under the Medical Care Plan—Paid for from Maternal and Child Health Funds. To be forwarded to Bureau of Maternal and Child Health, Room 430, Broad Street Bank Bldg., Trenton, N. J.

Name of Patient .....  
Address ..... Age.....  
Final Diagnosis .....  
Complications .....  
Summary of Treatment .....  
If in Hospital—No. of Days' Stay .....  
No. of Examinations by Physician—  
At Home..... Office..... Hospital.....

Condition on Discharge—Recovered .....  
Improved..... Unimproved..... Dead.....  
Signature Physician .....  
Address .....  
Name of Hospital ..... Date.....

Use opposite side for any further remarks  
Forms to be obtained from Bureau of Maternal and Child Health.

The Prenatal Record Form shown below was prepared by the Committee on Maternal Welfare of The Medical Society of New Jersey and is distributed by the Bureau of Maternal and Child Health of the New Jersey State Department of Health, in which Dr. Bingham, Chairman of the Maternal Welfare Committee, is Consultant on Maternal Welfare.

PRENATAL HISTORY CARD

Name ..... Address ..... Age ..... Grav. .... Para. ....  
Nature of ..... Normal ..... Persistent Vomiting .....  
Previous Pregnancies ..... Toxic ..... Kidney Disease .....  
Nature of ..... Normal ..... Instrumental ..... Caesarian .....  
Previous Labors ..... Precipitate ..... Prolonged ..... Why? .....  
.....  
Miscarriages ..... Month ..... Premature Births .....  
Last ..... Cured ..... Stillbirths .....  
..... Probable Date .....  
Menstruation ..... Quickening ..... of Delivery .....  
Distance { Spines ..... Right Oblique ..... Ext. Conjugate ..... Transverse Outlet .....  
between { Crests ..... Left Oblique ..... True Conjugate ..... Pubic Arch.....  
Nipples { Erect ..... Physical ..... Heart ..... Lungs .....  
          { Flat ..... Exam. .... Abdomen ..... Teeth .....  
          { Inverted .....  
Previous Illness .....  
Operations .....  
Family History .....  
Personal History ..... Wassermann .....  
Follow-up .....  
Exam. (6 weeks) Wgt. .... B. P. .... Gen. Condition ..... Nursing Baby .....  
Date ..... Uterus ..... Adnexa ..... Cervix ..... Perineum .....

(over)

Date	Weight	Blood Pressure	Urine	Hbg.	Fundus	Cervix	Foetal Heart	Presen- tation	Toxic Symptoms	NOTES

Delivery Date ..... Hour ..... Type .....  
Length of Labor ..... Analgesic ..... Anesthetic .....  
Perineum—Intact ..... Lacerated ..... Episiotomy ..... Sutures .....  
Cervix—Intact ..... Lacerated ..... Sutures .....  
Hemorrhage ..... Treatment .....  
Baby—Sex ..... Weight .....  
Puerperium—Normal ..... Abnormal .....  
Remarks .....



## WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ANTOPOL, WILLIAM (Newark)—with Arthur Schiffrin and Lester Tuchman, New York

Diagnostic value of serum cholinesterase determinations in jaundice and in cirrhosis of the liver. *Am. J. Digest. Dis.*, 9: 342-347, Oct. '42

BERNSTEIN, ARTHUR, and AARON E. PARSONNET (Newark)

1. Heart strain: a critical review; the development of a physiologic concept. *Annals of Int. Med.*, 16: 1123, June '42

2. Myocarditis: diagnosis and treatment. *Medical Times*, 70: 257, Aug. '42

BICK, EDGAR M., Maj. M.C., U.S.A., and HOMER C. PHEASANT, Capt. M.C., U.S.A. (Fort Monmouth, Red Bank)

Local application of sulfonamides to synovial surfaces. *J. Bone & Joint Surg.*, 24: 937-939, Oct. '42

BRAKELEY, ELIZABETH (Montclair)

Leukemia resembling chloroma. *Am. J. Dis. Child.*, 64: 689-696, Oct. '42

BRANCH, W. HAROLD (Jersey City)

Recurrent rheumatic endocarditis with terminal hyperpyrexia. *J. Nat. M. A.*, 34: 194-196, Sept. '42

COHN, GEORGE M. (Newark)—see Finkler, Rita S.

FINKLER, RITA S.; NATHAN J. FURST and GEORGE M. COHN (Newark)

Present status of the use of male sex hormones and chorionic gonadotropins as growth stimulating factors. *J. Clin. Endocrinol.*, 2: 603-610, Oct. '42

FURST, NATHAN J. (Newark)—see Finkler, Rita S.

GERBER, ISADORE E. (Jersey City)—see Kruger, Alfred L.

KRAEMER, MANFRED (Newark)

1. Use of sulfaguanidine for ulcerative colitis. *Am. J. Dig. Dis.*, 9: 356-357, Oct. '42

2. (With Leslie Townsend, Roselle.) Chronic gastric ulcer in a six-year-old child. *Am. J. Dig. Dis.*, 9: 338-340, Oct. '42

KRUGER, ALFRED L., and ISADORE E. GERGER (Jersey City)

Bromsulphalein liver function test in pulmonary tuberculosis. *Am. Rev. Tuberc.*, 46: 439-444, Oct. '42

MARLETT, N. C. (Belvidere)—see Plume, C. A.

MOUNT, WALTER B. (Montclair)

Bibliography and source material, life of Edward J. Ill, not published. On file Academy of Medicine of Northern New Jersey, Newark, N. J.

NEWMAN, JULIUS (Newark)

Repair of prognathic and retruded jaws. *Am. J. Surg.*, 58: 35-39, Oct. '42

ORTON, HENRY BOYLAN (Newark)

Lateral transthyroid pharyngotomy. *Ann. Otol. Rhin. & Laryng.*, 51: 774-779, Sept. '42

PARSONNET, AARON E. (Newark)—see Bernstein, Arthur

PHEASANT, HOMER C. (Fort Monmouth, Red Bank)—see Bick, Edgar M.

PLUME, C. A. (Succasunna) and N. C. MARLETT (Belvidere)—with Lemuel C. McGee (Wilmington, Del.) and Alexander McCausland (Blacksburg, Va.)

Metabolic disturbances in workers exposed to dinitrotoluene. *Am. J. Dig. Dis.*, 9: 329-332, Oct. '42

STREIJINGER, ALEXANDER (Elizabeth)

Acute postoperative lung abscess. *J. Lab. & Clin. Med.*, 27: 1510-1516, Sept. '42

TOWNSEND, LESLIE (Roselle)—see Kraemer, Manfred (2)

## MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES

### SUPPLEMENTARY LIST NUMBER SIX

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Agolia, Michael W., Union City (9)  
Applebaum, Irving L., Newark (7)  
Aria, Charles J., Jersey City (9)  
Arndt, Frank R., North Bergen (9)  
Artaserse, George V., Jersey City (9)  
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Balles, Edward S., Paterson (16)  
Balson, Zachery D. B., Newark (7)  
Barbour, George E., Somerville (18)  
Barnes, William J., Englewood (2)

Barroway, James N., Camden (4)  
Bergsma, Daniel, Trenton (11)  
Berlin, Morris R., Newark (7)  
Betancourt, Raul R., Camden (4)  
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Bobadilla, Juan E., Dover (14)  
Booth, William K., Boonton (14)  
Borrella, Dominic D., Trenton (11)  
Bowen, Robert N., Woodlynn (4)  
Boyd, Robert P., Fanwood (20)  
Boyle, Francis L., Bayonne (9)  
Branon, Mark E., Rutherford (2)

- Brauer, Selig J., Jersey City (9)  
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 Bump, Samuel C., Ridgewood (2)  
 Burbidge, John R., Princeton (11)  
 Burns, Wilmer F., Audubon (4)  
 Captanian, Aram A., Matawan (13)  
 Carsley, Sidney H., Cranford (20)  
 Cerone, Daniel M., Glen Ridge (7)  
 Charleroy, Durant K., Bordentown (11)  
 Charnock, M. P., Trenton (11)  
 Ciampa, Ralph, Long Branch (13)  
 Cieri, Daniel S., Union City (9)  
 Cochrane, Cleland D., Closter (2)  
 Cohen, Nathan B., Perth Amboy (12)  
 Cohen, Paul, Camden (4)  
 Connolly, Joseph P., Paterson (16)  
 Conway, James V., Elizabeth (20)  
 Cooper, Robert A., Camden (4)  
 Copleman, Benjamin, Perth Amboy (12)  
 Coughlin, John, Jersey City (9)  
 Coughlin, Joseph J., Ridgefield Park (2)  
 Coxson, Harold P., Stratford (4)  
 Curtis, Donald A., Hackensack (2)  
 Danielson, John J., North Bergen (9)  
 Davis, E. Vernon, Vincentown (3)  
 DeBiasco, Cornelius V., Rutherford (2)  
 Degenhardt, Ira H., New Brunswick (12)  
 Deichman, Charles H., Morristown (14)  
 Deitz, Joseph R., Trenton (11)  
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 Dempsey, John H., Berlin (4)  
 DiFelsi, Anthony J., Camden (4)  
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 Ein, William B., South Orange (7)  
 Evans, Edgar J., Denville (14)  
 Faber, Edward, Jersey City (9)  
 Farrell, Edgar A., Haddonfield (4)  
 Fattel, Henry C., North Bergen (9)  
 Fazio, Vincent J., South Amboy (12)  
 Featherston, Daniel F., Asbury Park (13)  
 Federer, John J., Weehawken (9)  
 Feinberg, Harry, Bayonne (9)  
 Feinberg, Harry D., Long Branch (13)  
 Feldman, Joel, Rumson (13)  
 Fenimore, Edward D., Jersey City (9)  
 Fessman, John W., Runnemede (4)  
 Fink, Stanley J., Roselle (20)  
 Finkle, Lester J., Trenton (11)  
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 Friedman, Abraham I., Hackensack (2)  
 Gamba, Joseph, Newark (7)  
 Gannon, Joseph M., Plainfield (20)  
 Gebirtig, Theodore, Greystone Park (14)  
 German, George B., Camden (4)  
 Gerne, Timothy A., Jersey City (9)  
 Gershamann, Joseph G., Dumont (2)  
 Giglio, Alphonsus S. V., Elizabeth (20)  
 Gittelman, Morton, Elizabeth (20)  
 Glasser, Benjamin F., New Brunswick (12)  
 Golden, William M., Rahway (20)  
 Goldman, Leo L., Trenton (11)  
 Goldstein, Henry Z., Newark (7)  
 Gorenberg, Harold, Jersey City (9)  
 Gorog, Nicholas M., New Brunswick (12)  
 Gracter, Fritz A., Passaic (16)  
 Greenberg, George A., Somerville (18)  
 Greene, Harry, Jersey City (9)  
 Grenhart, George W., Camden (4)  
 Griffey, William C., Westmont (4)  
 Gross, Isidore, Verona (7)  
 Halbstein, Bernard M., Long Branch (13)  
 Halnan, John J., Jr., Paterson (16)  
 Hamley, John J., Elizabeth (7)  
 Harrington, J. Henry, Rockaway (14)  
 Harz, William V., Bayonne (9)  
 Heaton, Stuart C., Bound Brook (18)  
 Hemphill, Everett H., Haddonfield (4)  
 Hiden, Joseph C., Princeton (11)  
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 Jacobson, Murray B., Perth Amboy (12)  
 Jaffe, Benjamin, Jersey City (9)  
 Joffe, Phillip M., Paterson (16)  
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 Johnson, Herbert F., Collingswood (4)  
 Johnston, Sidney F., Rochelle Park (2)  
 Judson, G. Vernon, Jr., Barrington (4)  
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 Keating, Joseph M., Passaic (16)  
 Kelly, Harry R. J., Union City (9)  
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 Kessell, John S., East Orange (7)  
 Keyser, David, Camden (4)  
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 Knowles, George M., Hackensack (2)  
 Koerber, George, Passaic (16)  
 Kohut, George J., Perth Amboy (12)  
 Kraisel, Cornelius J., Hackensack (2)  
 Kramer, Douglas W., Plainfield (20)  
 Kratka, William H. C., Bridgeton (6)  
 Kuder, Joseph M., Mt. Holly (3)  
 Kutner, Charles, Camden (4)  
 Lane, Thomas F., Jersey City (9)  
 Lang, Joseph, Perth Amboy (12)  
 Laudig, Guy H., Morris Plains (14)  
 Lavine, Samuel C., New Brunswick (12)  
 Lee, Benjamin F., Jr., Camden (4)  
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 Lepis, A. Albert, Jersey City (9)  
 Liccese, Emanuel, Newark (7)  
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 Magee, Edward S., Oaklyn (4)  
 Mancene, Edward M., Little Ferry (2)  
 Maroney, James H., Summit (20)  
 Mason, Howard B., Freehold (13)  
 McAlpine, Paul, Summit (20)  
 McCarthy, John J., North Bergen (9)  
 McCluskey, Harry B., Whippany (14)  
 McDermott, Vincent T., Camden (4)  
 McLoughlin, John W., Bayonne (9)  
 Mecray, Paul, Jr., Camden (4)  
 Meisel, David B., Newark (7)  
 Mickewich, Stephen A., Bayonne (9)  
 Miller, Theodore R., Ridgewood (7)  
 Miller, William H., Woodstown (17)  
 Mishell, Daniel R., Maplewood (7)  
 Moriconi, Albert F., Trenton (11)  
 Muccia, John J., Jersey City (9)  
 Murray, Norman L., Summit (20)

- Netz, Lester W., Hackensack (2)  
Ney, J. Marshall, Newark (7)  
Niemtzow, Frank, Freehold (13)  
Nobile, James J., Hoboken (9)  
Nussbaum, Nathan, Paterson (16)  
O'Connell, James J., New Brunswick (12)  
Oren, Hyman, Park Ridge (2)  
Ornaf, I. Edward, Camden (4)  
Ortolano, James J., Hoboken (9)  
Osborn, Edward G., Camden (4)  
O'Shea, John J., Weehawken (9)  
Pallen, Conde deS., Rochelle Park (2)  
Parent, Sol, Newark (7)  
Parsonnet, Aaron E., Newark (7)  
Pellicane, Anthony J., New Brunswick (12)  
Perry, Frank L., Woodstown (17)  
Piasecki, Chester A., Paterson (16)  
Pinsky, Harry A., Camden (4)  
Pleasants, Edward N., Marlboro (13)  
Pons, Carlos A., Asbury Park (13)  
Preece, John D., Trenton (9)  
Price, Henry S., Jr., Collingswood (4)  
Raab, Michael, Passaic (16)  
Rampona, Joseph M., Princeton (11)  
Reid, William T., Jr., Merchantville (4)  
Reinhorn, Abraham J., Paterson (16)  
Richlin, Padie, New Brunswick (12)  
Riegert, Louis C., Haddonfield (4)  
Riley, Philltus H., Morristown (14)  
Ristine, Edwin R., Camden (4)  
Roseman, Herman I., Montclair (7)  
Rosen, Charles E., Union City (9)  
Rosenberg, Max, Hillside (7)  
Rosenthal, Abraham, Atlantic Highlands (13)  
Rubenstein, Robert, Jersey City (9)  
Rubin, Harold, Asbury Park (13)  
Rubin, Samuel, Whippany (14)  
Rudolph, John P., Merchantville (4)  
Sabini, Cecil F., Hoboken (9)  
Sacco, Gregory E., Red Bank (13)  
Sackin, Stanley, Trenton (11)  
Samuels, S. Lawrence, Plainfield (20)  
Santosky, Benjamin B., Jersey City (9)  
Savel, Lewis E., Newark (7)  
Sayers, Francis P., Penns Grove (17)  
Schenker, Benjamin N., Jersey City (9)  
Schirber, Rene G., New Brunswick (12)  
Schwartz, Henry C., Atco (4)  
Schwartz, Jacob R., Fair Lawn (16)  
Schwartzberg, Frederick I., Paterson (16)  
Seto, Sanford P., Blackwood (4)  
Seybold, Arthur D., Plainfield (20)  
Shafer, Albert H., Camden (4)  
Shaul, John F., Bloomfield (7)  
Silich, Robert L., Weehawken (9)  
Silverman, S. Andrew, Newark (7)  
Simeone, Peter A., Union City (9)  
Smalzried, Elmer W., East Orange (7)  
Smith, Bertram H., Haddon Heights (4)  
Sokoloff, Oscar J., New Brunswick (12)  
Spaldo, John L., Somerville (18)  
Spivack, David, Elizabeth (20)  
Stefansin, Frank, North Bergen (9)  
Stein, Joseph M., Camden (4)  
Stein, William, New Brunswick (12)  
Steinberg, Benjamin L., Singac (16)  
Stephenson, Daniel H., Camden (4)  
Stevenson, G. McKay, Summit (20)  
Stoddard, Gordon V., East Orange (7)  
Strauss, Arthur, Long Branch (13)  
Sussman, Harold, Union City (9)  
Sutnick, Theodore B., Trenton (11)  
Swieczicki, Martin E., Barrington (4)  
Taft, Herman L., North Bergen (9)  
Taranto, Michael, Linden (20)  
Tatem, Henry R., Jr., Audubon (4)  
Terrerf, D. Joseph, Morristown (14)  
Thron, Leopold E., Paterson (16)  
Ulvestad, Lawrence E., East Orange (7)  
Utkewicz, Edmond A., Jersey City (9)  
Visceglia, Frank R., Passaic (16)  
Wagner, Richard, Elizabeth (20)  
Wallach, Bernard, North Plainfield (18)  
Warwick, Ralph A., Camden (4)  
Waugh, Bascom S., Camden (4)  
Welkind, Allen A., Newark (7)  
West, David H., Camden (4)  
White, Thomas J., Jersey City (9)  
Wolbert, Charles M., Cliffside Park (9)  
Wolfe, Edward E., Teaneck (2)  
Wolff, Herbert M., Trenton (11)  
Wolfson, Harry, Paterson (16)  
Wood, E. LeRoy, Newark (7)  
Woodman, Charles, Morristown (14)  
Yudkoff, William, Bayonne (9)

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## SUPPLEMENTARY LIST OF MEMBERS NO. 7

### TO THE OFFICIAL LIST OF MARCH 15, 1942

#### ACTIVE MEMBERS

- Cohen, Harry, 1 Garden Drive, Roselle (20)  
Colman, Peter F., 80 Monmouth Rd., Oakhurst (13)  
Filkins, C. E., 412 White Horse Pike, Audubon (4)  
Jarecki, Max, 527 Bangs av., Asbury Park (13)  
Lovett, Irving K., 110 E. Front st., Red Bank (13)  
Miller, Theodore R., 617 Linwood av., Ridgewood (7)  
Pellicane, A. J., Fort Leonard Wood, Missouri (12)  
Smalzried, Elmer W., U.S.S. Pastores, care of Postmaster, N. Y. C. (7)  
Strauss, Leo, 18 S. Munn av., East Orange (7)  
Wolfe, Edward E., 895 Queen Anne Road, Teaneck (2)

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## DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
James Atkinson	81	July 26, 1942	Glen Rock	Same	Chr. coronary artery dis.
Edwin H. Coward	56	June 10, 1942	Northfield	Same	Coronary thrombosis.
John L. MacDowell	61	July 21, 1942	Perth Amboy	Same	Coronary thrombosis.
Luigi S. Michela	66	Aug. 21, 1942	Paterson	Same	Acute cardiac failure.
James J. Rowland	55	July 31, 1942	Highlands	Same	Coronary thrombosis.
Frederick A. Wild	70	July 14, 1942	Plainfield	Bound Brook	Carcinoma prostate gland.



# • THE BULLETIN BOARD •

## MEETINGS

Dr. Leon Herman of Philadelphia will speak on "Difficulties Encountered in the Interpretation of Genito-Urinary Symptoms" before the Gloucester County Medical Society at 9 p. m. on *November 19* at the Country Club in Woodbury.

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A Symposium on Rectal Cancer was held by the New Amsterdam Hospital, 500 West Fifty-seventh Street, New York City, on October 14, 1942. The following doctors participated: Drs. Frank C. Yeomans, George E. Binkley and Arthur A. Landsman.

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The Third Annual Medical Meeting of the National Foundation for Infantile Paralysis will be held in the New York Academy of Medicine on *December 3-4* inclusive.

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## NEW HEALTH FILMS

"Enemy X", a new film on cancer, treats the subject in a new and interesting way. This film is available from The American Society for the Control of Cancer, 250 Madison Avenue, New York City.

"Middletown Goes to War" was just released by the State Tuberculosis League. It is a very timely film for those communities that are facing the problems of crowded war industry. Apply to the New Jersey Tuberculosis League, East Kinney Street, Newark, N. J.

"Peptic Ulcer", the first complete movie film on peptic ulcer, in color and with sound track, is now available for free showings before groups of physicians. It was produced under the direction of the Department of Gastroenterology of the Lahey Clinic of Boston, and the American College of Surgeons has awarded its seal of approval to the film. Running time of the film is 45 minutes, 1,600 feet of 16 mm. film, and covers a presentation of the following problems of peptic ulcer: Pathogenesis, diagnosis, treatment, pathology, complications, including obstruction, hemorrhage, and perforation, gastric ulcer, surgery and jejunal ulcer. Arrangements for a showing of the film may be made by writing to the Professional Service Department of John Wyeth & Brother, Inc., Philadelphia, who will

provide projection equipment, screen, film and operator for medical groups without charge.

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## PUBLIC HEALTH NEWS

Members of The Medical Society are strongly urged to read the issues of Public Health News which are sent to them by the State Department of Health. In the current August issue are several articles of value to practicing physicians, for example the two articles on venereal disease control, especially the one by Dr. Daniel Bergsma, now in the Army Service. This article, which begins on page 114, is called "Blood Testing During the February Registration Days" and it relates to the experience, supplementing the earlier report in the Public Health News of February, 1942, showing the results of the Wassermann testing of thousands of draftees. In the current report by Dr. Bergsma more than 46,000 men were tested and there were 2,145 positive tests and 1,146 doubtful tests. Patients confronted with the fact that they are in need of medical treatment are then referred to private practitioners and clinics for indigents, thus protecting the public against innocent or wilful transmission of the disease to others, and greatly benefiting those already infected. The geological and racial distribution of the persons tested is shown in a chart accompanying Dr. Bergsma's article.

Another important inclusion in the Public Health News of August is a brief biographical sketch of the new members on the State Board of Health. A review of this data will emphasize the care shown by Governor Edison in his selection of these new Board members, all of whom have a record of preparation and achievement which merits confidence in their contributions to the State Department of Health.

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## CHAIRMAN OF SECOND CORPS AREA

Dr. Henry W. Cave, who has been serving as State Chairman for Physicians in New York of the Procurement and Assignment Service, has been appointed by Paul V. McNutt, Federal Security Administrator and Chief of War Manpower Commission, as Chairman of the Second Corps Area of the Procurement and Assignment Service. The Second Corps Area embraces the states of New York, New Jersey and Delaware.

## COUNTY SOCIETY REPORTERS

The function of a reporter is to give the news of *his* society to the members who read *The Journal of the State Society*. This purpose again brings up the old question of what is "news". President Marsh gave us some help on this subject at the last Annual Meeting. He pointed out the difference in function between the Secretary, who reports primarily for current use the procedure followed, decisions reached and guiding policies established at the official meetings of the County Medical Society, and the Reporter, who records the interesting facts concerning special plans, events, personalities, health conditions prevailing as well as the visits of physicians to or from their county for professional or other reasons. These reports make history writing possible at some future time and provide as well an interesting account of present-day news. The details of formal meetings are for Secretaries—the side-lights and highlights are the responsibilities of the Reporter.

County Medical Society Reporters today have a wealth of news to pass along and to record for posterity. Members are interested in knowing who is where and why, because we are at war. Who likes, or dislikes what in his new experience and why. Out of this new experience many suggestions of value to his colleagues can be offered to help the next fellow avoid the same mistakes. What is being done for civilian defense in your county and how is it being done? What improvements in doing this job can *you* suggest? Give us the facts and we will help in the editing of the presentation if you are hurried in its preparation. We physicians take things we have learned for granted even when there is so much that others would like to know about what has already been learned. Pass along the NEWS regularly.

In reporting on the address of a scientific speaker at the meetings of the County Medical Society, it is well not to attempt to repeat his talk in detail, but rather to state the subject and the points he discussed. In this way one avoids the danger of garbling his statements and robbing his talk of the attention it deserves when he is asked to give it before another County Society. For example, the reporter can state that "Dr. A discussed the subject of 'War Injuries' and described vividly the effect of the gases used, the burns resulting, the de-

structive effect upon the respiratory system, the toxic manifestations and the fatality statistics. He emphasized the types of injuries inflicted by shrapnel, rifle bullets and machine guns; by bomb splinters; the bayonet and concussion-blasts which are now better understood and also better cared for as a result. His entire talk was both interesting and practical in application. One could benefit immediately by such first-hand experience and advice, and the speaker will be welcomed at any time he will favor us with his presence in the future." Such a report will stimulate interest in other Societies, will give a suggestion as to the content and will not garble the statements of the speaker.

The length of the report cannot be standardized without detriment, for it will vary considerably from time to time. It should, stated a noted writer, "be like a woman's skirt,—long enough to cover the subject properly, but short enough to be interesting." On the average one can say a great deal in three hundred to five hundred words. Rarely a few more are essential. Good writers make every word count, and editors must constantly eliminate words from papers submitted, in order to find out what the writer is endeavoring to say. Newspapers have "rewrite men" who take what the reporters send in and reword it for clarity and brevity, before it is published. There is also the element of cost involved, for unnecessary words cost money when printed. The editor will assist the County Society Reporters in the *wording* if they will supply the *facts*.

Wordy resolutions and obituaries are not of great interest except locally. They need not be reported in detail unless they are of especial significance. One may just state that resolutions were passed or obituary presented relating to Dr. ———.

The reporter should formulate first in his mind what he wants to say. He can then say it clearly and concisely. Then he should edit it to see if the omission of certain words will make clearer his meaning. He will be surprised how many words are unnecessary and really make more obscure his main points of emphasis. The Reporter should send in his reports regularly and promptly—never later than the 25th of the current month. *The Journal* must be in the mail on the tenth of the next month, and time is required to prepare the material.

## COUNTY SOCIETY REPORTS

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The October meeting of the *Burlington County Medical Society* was held on the eighth of the month in Moorestown. PRESIDENT SCOTT welcomed to the meeting CAPTAIN A. L. CHAPMAN of the United States Public Health Service, who has replaced DR. ROBERT STRODE as the Public Health Officer of Burlington County.

Upon the recommendation of the Board of Censors, CHARLES F. GIBSON, M.D., of Burlington was elected to the County Society.

The vacancy on the Legislative Committee which was caused when DR. JOSEPH M. KUDER joined the Army Medical Corps was filled by the election of DR. S. EMLINE STOKES to the post.

DR. WILLIAM BRAY was appointed to conduct the Baby Keep-Well Clinic at Wrightstown.

The guest speaker was LIEUTENANT COMMANDER STEPHEN CASPER, M.D., Assistant Roentgenologist of Jefferson Medical College Hospital, who spoke on the topic "Common Fallacies in X-ray Diagnosis". He stressed the importance of the proper preparation of the patient. He showed how the correct diagnosis could be hidden by the improper preparation. Dr. Casper suggested that when several x-ray examinations are to be performed on a patient the roentgenologist be consulted first as there is a proper and improper sequence. The lecture was illustrated with slides. Dr. Casper gave the Society a very instructive talk and it was thoroughly appreciated.

The November meeting will be held at the Burlington County Hospital in Mt. Holly on November 12 at 4:00 p.m.

### MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

The first of our 1942-43 series of meetings was held at the New Jersey State Hospital, Greystone Park, Thursday evening, October 15th, at 8:45 p.m., before a smaller number of members and guests than usual as a result of the absence of many members who are now in the Armed Forces. DR. NORMAN SCOTT and MAJOR H. A. COTTON, JR., M.C., were our distinguished guests, the latter being the speaker of the evening.

DR. MARCUS A. CURRY, Superintendent of the New Jersey State Hospital, introduced Major Cotton, whose topic was "Psychiatric Problems in the Armed Forces". Major Cotton, now stationed at the Tilton Hospital, was formerly connected with the Mental Hygiene Department at Trenton.

Major Cotton, in his address, laid considerable stress on the following points:

1. Emotional upheaval is occurring at home as well as with the men actually in with the troops.

2. Fortunately the psychiatric casualties appear to be small among the civilian population both here and abroad.

3. The importance of the screening out of potential psychiatric cases both at the local boards and induction centers.

4. A fair number of men were inducted into the Army who have already been in state mental hospitals and for some reason or other this information has not come to the attention of the physicians at the induction centers.

5. The Army cannot use the epileptics or homosexuals, and the psychopaths and alcoholics as a whole do not do well and should be kept out.

6. The Army realizes the difficulty in screening the psychoneurotic group out as well as many of the types previously mentioned.

6. The psychiatric problems in the Armed Services is quite severe.

7. It was originally thought that 10 per cent of the Army hospital beds would be sufficient for psychiatric problems but it has developed that this is not enough.

8. It was interesting to note that the psychoses which developed in the Army differ considerably from those of civilian life in that they are more acute and more difficult to classify but the prognosis seems better.

9. The problem of malingering of course continues difficult to solve, even if proven it would be doubtful that the malingerer would be of any value as a soldier.

10. Major Cotton mentioned several factors involved in precipitating a psychosis, for instance the waiting and anticipating combat and then again there are the reactions that occur after the shooting is over.

11. The problem of rehabilitation of psychiatric problems dismissed from the Army becomes distinctly a civilian responsibility.

Major Cotton's interesting talk stimulated a discussion, which was participated in by a number of the members present, on that subject.

DR. SCOTT briefly talked about procurement and assignment and stated that an attempt had been made to leave sufficient doctors in civilian life so that the ratio would be one doctor to fifteen hundred civilians. However, it is feared that with a further increase in the size of the Army and the demands for more physicians, that this ratio will have to be changed to perhaps one physician to two thousand civilians. He also reported that the State of New Jersey has so far furnished about sixteen hundred physicians in the Armed Services and that our quota will no doubt be increased.

DR. F. C. BOWERS, our President and presiding officer, requested that authorization from the Society be given to the Executive Committee to appoint a treasurer to fill the vacancy created as the result of DR. HARRINGTON's departure for the Army, which was granted and at the executive session held after the meeting, DR. VON DELEN was elected to fill the unexpired term of treasurer. The Executive Committee also authorized Dr. Bowers to ap-



point a committee to draw up a list of members of the Morris County Society, under the age of forty-five, in the order of their availability for military service, which would be used for the Office of Procurement and Assignment. The names of the members of the committee will be announced at a later date.

Two of our very active members have been ill, including Dr. B. G. SHERMAN and our Secretary and Treasurer of the State Society, Dr. GEORGE J. YOUNG. Our Executive Committee decided that in view of the pressure of work which has fallen on the remaining civilian physicians, it is necessary to curtail the number of meetings for the year and also our active post-graduate work would have to be indefinitely postponed. It is therefore planned to have four meetings during the year including the annual June meeting.

### PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held on Tuesday evening, October 20, 1942, at 9 p.m. at the new meeting place, the Freeholders Meeting Room in the County Administration Building in Paterson. Dr. THOMAS A. CLAY, the President, presided.

A large audience was present to hear Dr. HARRISON S. MARTLAND, Chief Medical Examiner of Essex County, lecture and present an exhibit of colored slides. His topic was "Pathological Specimens of Interest to Physicians and Surgeons", which together with his pointed and witty remarks was enjoyed by the members.

The business meeting was called to order and the following physicians were elected to membership in the Society:

ALBERT G. K. ANDREWS, M.D., Passaic  
LOUIS FRAULO, M.D., Clifton  
THEODORE POLLOCK, M.D., Clifton  
LEON H. S. THOMAS, M.D., Paterson  
J. HARRIS BROWN, M.D., Passaic  
RALPH C. YEAW, M.D., Paterson  
JOHN G. LIMA, Paterson  
JULIANA SCHWARZ, Passaic

Three applications for Active Membership have been received.

Dr. ANTHONY C. CICCONE read the following resolution on the death of Dr. LUIGI SAVERIO MICHELA:

"Dr. Luigi S. Michela passed from his earthly labors into the Life Eternal on August 21, 1942, of heart disease. Born in Turin, Italy, April 2, 1876, where he received his early education, and finally entering the University of Turin, where he received his medical degree in July, 1900. After practicing for several years in Italy he came to this country and practiced medicine in Paterson since 1910. During the First World War he served as Captain in the Italian Army, aiding the Allied cause in the Balkans and ultimately was discharged as Lieutenant Colonel. He then returned to Paterson and re-

sumed practice at 240 Carroll Street. He was a member of the Passaic County Medical Society and for the past fifteen years had served as Chief Obstetrician at St. Joseph Hospital.

"Highly devoted to his profession and specialty, he steadily grew in the esteem and confidence of his colleagues, who regarded him as a kind, sympathetic and willing friend.

"Wherefore, The Passaic County Medical Society deeply grieves the passing of such an esteemed member and resolves that the medical profession has lost a valued colleague and it directs that this minute be spread in full upon its record.

"(Signed) ANTHONY C. CICCONE, M.D.

FRED J. CRESCENT, M.D.

WILLIAM B. RUOCO, M.D."

Since soldiers or sailors in uniform should be treated by the medical department of the Army or Navy, Dr. CLAY made the announcement that civilian physicians should not treat them. He will receive an official announcement of this from the Surgeon-General's office of the Navy and Army in the near future.

A resolution was passed to reject a project financed by the W. P. A. to give injections for whooping cough and diphtheria.

Dr. ELIAS J. MARSH, President of the State Society, was called on to speak and he mentioned two current problems for discussion:

1. Osteopaths' requests for an M.D. degree with all privileges that go with it.

2. Organization of a U. S. P. H. S. corps which he felt might become an entering wedge for state medicine.

The meeting then adjourned.

### SUMMIT MEDICAL SOCIETY

C. S. Thomson, M.D., Secretary

The first meeting of the season of the *Summit Medical Society* was held at the Canfield Tea Room on Tuesday evening, October 27th, at 9 p.m.

Dr. MORRIS reported for the Nominating Committee as follows:

President, Dr. E. H. MACPHERSON

Vice-President, Dr. N. W. BURRITT

Secretary, Dr. C. S. THOMSON

Program Committee: Dr. M. S. EDGAR and Dr.

R. M. MILLER

The newly elected President, Dr. MACPHERSON, presided.

A telegram was received from the Past-President, Dr. STEUART, from Hattiesburg, Miss., where he is in service, wishing the Summit Medical Society an interesting and successful year and expressing his regards to all the members.

Dr. C. C. CARPENTER presented "Common Skin Conditions Seen in General Practice" with numerous colored slides. This was unusually interesting and instructive as it portrayed representative skin lesions from each group.

Following the meeting a collation was served.

# WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Temporary Chairman, Press and Publicity

## COMING EVENTS

### ATLANTIC COUNTY

November 13, 1942, 2:30 p. m.

Atlantic City Hospital Solarium

Speaker: Mrs. E. G. Shreve

Subject: More About Atlantic County Public Health

### ESSEX COUNTY

November 23, 1942, 2 p. m.

Academy of Medicine, Newark

Symposium: The Physician's Wife on the Home Front

Moderator: Mrs. Henry C. Barkhorn

Tea

### HUDSON COUNTY

December 7, 1942, 2 p. m.

Y. W. C. A., 270 Fairmount Avenue, Jersey City

Christmas Party

Tea

### OCEAN COUNTY

Meeting on call of President only for this year

### WARREN COUNTY

November 16, 1942, 1 p. m.

Residence: Mrs. Ralph Buchanan, 681 Barrymore Avenue, Phillipsburg

Business meeting

Luncheon

## STRONGER NOT WEAKER

Already there is talk of fewer meetings, of disbanding for the duration or of merely holding the allotted number of meetings that the county by-laws provide. This is the time for *strength*, for *unity* and for *singleness of purpose*.

After fifteen years' existence as a state-wide organization, comprised of separate component county units, the time of greatest opportunity for service that the Auxiliary has ever had, has arrived. Service with The Medical Society. The depletion of the personnel of the individual Societies, coupled with the even more hectic activity resulting for the physicians at home, offers the members of the Auxiliary a hundred opportunities to be of real help.

First, let us consider Public Relations Committee work in your own county. This is the natural forte of the Auxiliary—this is where we may serve our greatest purpose. For furthering the aims of the profession and as a link between physician and lay public, the doctor's wife is in the best possible position. This year your county society is probably considering curtailing, because it felt it must, the activities of this committee. Why not offer the services of your Auxiliary in some capacity? You say this is not directly connected with the war effort—that people look to you for war work? You can *make* it war work and make it also help your Medical Society Auxiliary. A large Auxiliary situated in the northern part of the state is doing this very thing. Following the lead of the National Public Health Department whose campaign slogan is "Amer-

ica Needs Us Strong", this group is sponsoring, with its local Board of Health, a Health Conservation Campaign. This program offers a sound movie, a speaker and a poster exhibit on polio, nutrition, cancer, venereal disease control in wartime and tuberculosis to all women's clubs in the county. These programs are available afternoon or evening and the subject is chosen by the clubs themselves. More than five hundred organizations have been contacted and it is confidently believed that before the year has passed almost the entire group of these organizations will have taken advantage of this health education campaign. This work can be done in small counties as well as in large ones, and proportionately, the same result is accomplished.

Next let us consider the increased load on the individual Auxiliary caused by the many demands upon its members by the Red Cross, Nurses Aide Courses, Canteen, Nutrition, Civilian Defense and a thousand other worthwhile, even indispensable groups. By all means do your work in these efforts. Doctors' wives have always responded to the cry for help. This help need not be to the detriment of your Medical Auxiliary. Integrate it with your own *organization*. Instead of Mrs. A being head of nutrition department of your local Red Cross, let Mrs. A, as head of this department, run it with the announced help of some of her own Auxiliary members. She may let it be known that this Red Cross department is assumed as the responsibility of the ——— County Auxiliary. An additional course is set up for Nurse's Aides, the idea being that this group will circulate through all the hospitals

of the county, giving help where it is needed most by the hospitals at that time. This requires a central office and what better place than one furnished and conducted by a County Medical Society Auxiliary.

Unless the County Auxiliaries realize that now is the time not only to help, but to hold together for our own sakes, we are going to find ourselves with a badly undermined organ-

ization when this war is over. These are not social gatherings that we can afford to dispense with—to take up again with a cup of tea when brighter times arrive. We are founded on service—and we must give it. Let's not talk of "staying together until this war is over". Let's take advantage of these times to become stronger, to be doers and to gain recognition as such.

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## STATE BOARD MEETING

The fall meeting of the State Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held on October 12 at the Trenton Country Club. Despite the many exigencies of travel there were fifty members present.

The morning business session convened at ten-thirty and opened with the welcoming address of Mrs. J. Howard Hornberger, President. The committees then reported and the County Presidents told of their plans for the year. It was decided to collect only 25 cents in dues from the county members whose hus-

bands are in the service. The usual dues are 60 cents per member.

After luncheon, delightfully planned by the Mercer County group, Dr. William E. Dodd and Dr. LeRoy A. Wilkes spoke to the members. Long respected as advisers to the State Board, the speakers stressed the importance of helping our own overworked physicians at home. Many small ways were outlined by Dr. Wilkes to relieve the doctor of efforts, all such thieves of time, which could be spared him by his wife. Full coöperation and an immediate entering into the war effort of our country was urged by Dr. Dodd.

The meeting adjourned at three o'clock.

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## PROGRAM

MRS. R. J. McDONALD, State Chairman of Program

The slogan set down by our National President, Mrs. Frank Haggard, "Working Together Is Success", seems to this writer to be a thought worthy of consideration. A practical application of this slogan would be to plan a well-rounded program for your Auxiliary.

Many avenues of activity are open for you and it is not the idea of your program chairman to lay down any hard and fast rules. It is wise for each county program chairman to consider the many suggestions which follow and to select the activities most suitable to your particular group.

Auxiliary members are no exception to the women throughout the country who are lending time, thought and effort in helping win the war.

Because of this situation many suggestions will bear on the war.

Following is a list of suggestions. Before setting them down I wish to emphasize certain ideas which pertain particularly to New Jersey.

New Jersey has an enormous number of de-

fense workers within its borders. As a result, hospital facilities are taxed to their utmost. Because of this it is advisable for the different county units to endeavor to have their members join up for a course in Nurse's Aides, Home Nursing, Canteen and Nutrition Courses.

These courses will be of inestimable value to the people in your community but also to the women who avail themselves of these courses. Your local Red Cross Chapter will welcome you to any of these classes or your Auxiliary may act as a sponsor for any of these courses.

Following are many suggestions for a program. Select the items which are best suited to the needs of your Auxiliary.

1. a. Special Study of Local Health Problems, particularly those made acute by military and defense plants.  
b. Study of health and defense work.
2. To appoint a Nutrition Council in each Auxiliary, for study of standard course



- in nutrition or advance course in canteen workers.
3. All Auxiliary members are especially urged to take a course in Home Nursing or use these lessons in place of a program.
  4.
    - a. New changes in medical government.
    - b. New medical legislation.
    - c. How women can help to control inflation.
  5.
    - a. Study about how medicine is practiced by our good neighbors in South America and Canada.
    - b. Defects of war in the English people.
  6.
    - a. Study about how the American doctor is helping to win the war.
    - b. New War Medicine—New medical methods which have been developed during this war.
  7. Stress more quiz programs this year. Send to National Chairman for a copy of "Be Informed" and base other quiz programs on this, using your County and State Auxiliary, State History, Hygeia, and the new Auxiliary Hand Book as a source of material for these quiz programs.
  8. Panel discussions, with County or State officials as guest leaders.
  9. In place of regular programs, give instructions in public speaking, so that the Auxiliary members may become well informed and interesting speakers on topics of health and medical economics.
  10. Every Auxiliary should review the survey of women's health interest which has been compiled by the Bureau of Health Education of the American Medical Association.
  11. The timely book review always makes an interesting program, particularly those on medical subjects.
  12. Morale and mental hygiene.
  13. What is a physical health examination? And how the American public, and especially the doctors' wives may keep fit by having a yearly check-up.
  14. Don't fail to include social gatherings in your program.
  15. Consult Hygeia and American Medical Association Journal for interesting program material.
  16. Current medical events are very essential in this rapidly changing world.
  17. How the various services have been organized by the National Physicians Committee of Extension of Medical Service.
  18. This year our National President is Mrs. Frank N. Haggard, of San Antonio, Texas; and if possible, arrange a date with her. She will be a source of great inspiration to your Auxiliary.
  19. A special program, Doctors' Day—Have a program on pioneer doctors of your community.

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#### Essex County

A luncheon meeting and business session opened the active season of the *Woman's Auxiliary to the Essex County Medical Society* at L. Bamberger & Company. The President, Mrs. Asher Yaguda, presided.

The Essex County Medical Society was represented by the President, Dr. William W. Cox, and Dr. Royal A. Schaaf, both of whom addressed the Auxiliary, commending its work.

Dr. Cox praised the members for their wool reclamation efforts in coöperation with Newark Chapter, American Red Cross. Dr. Cox also spoke of the Auxiliary's aid to his Society and his hope that the two societies would work even more closely together.

The Auxiliary's public relations work was told

by Mrs. Max Hummel, who has sent 500 letters to women's organizations asking their coöperation with the Medical Society's wartime health program. The program stressed the importance of making people health-conscious.

Mrs. Lodovico Mancusi-Ungaro reported on the wool conservation work, stating the committee had collected 7,500 pounds of wool clip, which is worth about \$700. She asked for more volunteer helpers in sorting.

Activities carried on at Camp Kilmer were reported by Mrs. Theodore B. Ford. Work to be done at the camp hospital was stressed, including the furnishing of a recreation room and a living room for doctors and nurses on the staff.

Mrs. Don A. Epler reported eleven new members.

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Three Emergency Medical Field Sets valued at \$330.00 were contributed by the Woman's Auxiliary to the Bergen County Medical Society to the Medical and Surgical Relief Committee of America and consigned to the Hackensack Hospital, Englewood Hospital and Holy Name Hospital in New Jersey.

One Emergency Medical Field Set valued at \$110.00 was contributed by the Woman's Auxiliary to the Middlesex County Medical Society of New Jersey to the Medical and Surgical Relief Committee of America and consigned to the Naval Supply Depot in Bayonne, N. J.

## BOOKS RECEIVED FOR REVIEW

**AFTER-EFFECTS OF BRAIN INJURIES IN WAR;** their evaluation and treatment. The application of psychologic methods in the clinic. By Kurt Goldstein, M.D. Foreword by D. Denny-Brown. Pp. 244. New York, Grune & Stratton. 1942. \$4.00.

**ABDOMINAL AND GENITO-URINARY INJURIES.** Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Pp. 243. Philadelphia, W. B. Saunders Company. 1942. \$3.00.

**OPHTHALMOLOGY AND OTOLARYNGOLOGY.** Prepared and edited by the Subcommittee on Ophthalmology and Otolaryngology of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Pp. 331. Philadelphia, W. B. Saunders Company. 1942. \$4.00.

**THE MIND AND ITS DISORDERS.** By James N. Brawner, M.D., Medical Superintendent, Brawner's Sanitarium, Smyrna, Georgia. Pp. 228. Smyrna, Ga., Walter W. Brown Publishing Co. 1942. \$3.50.

**TEXTBOOK OF FRACTURES AND DISLOCATIONS.** By Kellogg Speed, B.S., M.D., F.A.C.S. 4th ed. Philadelphia, Lea & Febiger. 1942. \$12.50.

**DOCTORS OF THE MIND, THE STORY OF PSYCHIATRY.** By Marie Beynon Ray. Pp. 335. Boston, Little, Brown & Company. 1942. \$3.00.

**MEDICAL PARASITOLOGY.** By James T. Culbertson. Pp. 285. New York, Columbia University Press. 1942. \$4.25.

**SULFANILAMIDE AND RELATED COMPOUNDS IN GENERAL PRACTICE.** By Wesley W. Spink, M.D., F.A.C.P. 2d ed. Pp. 374. Chicago, Year Book Publishers, Inc. 1942. \$3.00.

**PRINCIPLES AND PRACTICE OF MEDICINE.** Originally written by Sir William Osler, Bart., M.D., F.R.C.P., F.R.S. Designed for the use of practitioners and students of medicine. By Henry A. Christian, A.M., M.D., LL.D., Hon. Sc.D., Hon. F.R.C.P. (Can.), F.A.C.P. 14th ed. Pp. 1475. New York, D. Appleton-Century. 1942. \$9.50.

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## BOOK REVIEWS

**Synopsis of Allergy.** By Harry L. Alexander, A.B., M.D. Pp. 246. St. Louis, C. V. Mosby Company. 1941. \$3.00.

A concise practical application of allergy for the general practitioner will be found in this small and excellent book. All aspects are considered in proportion to their importance. It can be recommended as a good review book for students and practitioners.

**Treatment of the Patient Past Fifty.** By Ernest P. Boas, M.D. Pp. 324. The Year Book Publishers, Inc. Chicago. 1941. \$4.00.

The very definite increase in the population group over fifty years of age should mean an increasing medical interest in the diseases peculiar to the group. While most physicians are acquainted with the outward signs of aging, the symptoms are frequently misleading. With this increase in the population of those over fifty, the geriatrician may soon become an equally prominent professional group as the pediatrician. In some instances as in nutritional conditions, the treatment may well be identical in infancy and in old age. The physician who finds the group over fifty becoming a larger and more prominent part of his practice will at times need an experienced guide.

The first four chapters of "Treatment of the Patient Past Fifty" offer to the general practitioner an excellent guide in the general management, diagnosis and treatment of this group.

As might be expected, the chapters on the cardiovascular system are extensive and intensive, offering to the reader far more than the title of the book suggests. The single chapter on diseases of bones and joints and gout, consisting of twenty pages, hardly seems to cover the field. With "some 6,850,000 cases of rheumatism in the United States", many arthritic clinics, and the work of the Amer-

ican Rheumatism Association, this group of degenerative diseases is given all too little attention.

Gold is a valuable agent in rheumatoid arthritis, but the physician is advised to consult the most recent authoritative literature. The author might well have given us a more extended account of the treatment with gold, its dosage, untoward and toxic effects, and what we might expect in results. Prostatic massage every day or every other day seems to this reviewer a bit frequent, particularly so after sixty. Perhaps a little less often would not be so wearing on the patient.

The statement (page 224), "There is no evidence that there is a male climateric analogous to the female climateric \* \* \* there are no accompanying constitutional symptoms." To anyone who has listened to the evidence offered by those between forty-five and sixty, this would hardly seem a fair statement.

The subject of aging from the clinical point of view is ably handled. The general management of the aged is probably of far more importance than the palliative treatment used for most of the aging symptoms. This chapter on the general management of the aged is perhaps the most important in the book.

C. P. S.

**Dr. Colwell's Daily Log for Physicians,** a blank book for the financial record of the physician's daily business with monthly summaries. Price \$6.00. Colwell Publishing Co., Champaign, Ill.

Dr. Colwell's Daily Log for Physicians continues to offer one of the most helpful systems of recording the various financial and professional data involved in the private practice of medicine. Records of this type are especially valuable in the light of the increasing governmental concern over professional practice and income, and the high qualities

which hitherto marked the Daily Log have been continued in the 1943 issue. For those physicians who have not had extensive training in the keeping of financial and business records, the procedure here outlined, together with the summary records periodically entered by the careful physician, will place at his fingertips the type of information that will be of immeasurable help and value to him. The attractive and convenient form in which this data is made available makes it appeal to physicians, many of whom have been using this system for a considerable number of years.

L. A. W.

**The 1941 Year Book of Industrial and Orthopedic Surgery.** Ed. by Charles F. Painter, M.D. Pp. 432. Chicago, Year Book Publishers, Inc. 1941. \$3.00.

This book is a compact ready reference abstract of the year's progress in orthopedic surgery. The articles are carefully selected and conveniently arranged under systems. It should be of considerable value to the general practitioner since the articles are so carefully selected from the great mass of literature.

Orthopedic surgery takes up the greatest part of the volume and industrial surgery and medicine only about one-fourth. The latter subjects are as carefully selected and abstracted as those on orthopedic surgery. It seems to the reviewer, however, that the two subjects might very well be separated. The advisability of combining them under one cover is questionable.

LEOPOLD SZERLIP, M.D.

**Manual of Pharmacology and Its Application to Therapeutics and Toxicology.** By Torald Sollmann, M.D. 6th ed. Pp. 1298. Philadelphia, W. B. Saunders Company. 1942. \$8.75.

The sixth edition, completely revised, of this book remains as one of the foremost texts and ready reference books on pharmacology. Entirely rewritten with English titles, it has brought up to date the latest advances in modern medicine. There are sections on war gases, irritants with a general outline of treatment, lead poisoning, the sulphonamide compounds, vitamins and hormones, prescription writing, incompatibility and toxicology. It can be recommended as a valuable addition to any physician's library.

LOUIS SIMONSON, M.D.

**Surgery of the Ambulatory Patient.** By L. Kraeer Ferguson, A.B., M.D., F.A.C.S., with a section on fractures by Louis Kaplan, A.B., M.D., F.A.C.S. Pp. 923. Philadelphia, J. B. Lippincott Company. 1942. \$10.00.

Surgery of the Ambulatory Patient can be well recommended and should be especially helpful to the younger men and general practitioners. The lesions discussed are those that can be treated in the office or in the out-patient clinic.

The book is divided into three sections. The first deals with typical lesions with description, course and care. The second part is on regional surgery and methods of treatment. The third and last deals

with fractures and dislocations of the ambulatory type ably written by Dr. Louis Kaplan.

The material has been assembled and arranged in such a way as to make for easy as well as interesting reading. This is a highly satisfactory book and fills a need long felt for the treatment of patients who do not have to be hospitalized.

ERNEST GENNELL, M.D.

**Management of the Sick Infant and Child.** By Langley Porter, B.S., M.D., M.R.C.S. (Eng), L.R.C.P. (Lond.), and William E. Carter, MD. 6th ed. Pp. 977. St. Louis, C. V. Mosby Company. 1942. \$11.50.

Clearness and conciseness characterize this last edition of Porter and Carter's *Management of the Sick Infant and Child* and with it the authors succeed in covering all the fundamentals necessary in the treatment of children. The chapter divisions are well selected and simplify the references for the reader. The chapter on "Methods" is extensive and should be a great help to the pediatrician in reviewing procedures which he does not practice every day and to the general practitioner as well. The chapter on formulas and recipes is well worth a careful perusal by any doctor who wishes to make up a diet list for the young.

MAURICE L. RIPPS, M.D.

**War Medicine; a symposium.** Edited by Winfield Scott Pugh, M.D.; Edward Podolsky, M.D., Associate Editor, and Dagobert D. Runes, Ph.D., Technical Editor. Pp. 565. New York, The Philosophical Library. 1942. \$7.50.

For many new medical officers of our fighting forces and for civilian physicians who contemplate ministering to victims of enemy action, *War Medicine* presents a view of problems to be confronted. The book contains 57 monographs collected and reprinted from representative journals. Thirty-three of the articles are in the surgery section, fourteen are in the general medicine section with ten in the section entitled aviation and naval medicine. Most of the articles are timely, considering current war problems, while a few present lessons learned in World War I. If the original publication dates of the articles had been indicated, it would have added interest. The volume provides the convenience of having a selected group of articles on various aspects of war medicine presented within the covers of one book.

EARL LEROY WOOD, M.D.

**Stedman's Practical Medical Dictionary.** 15th ed. Rev. by Stanley Thomas Garber, B.S., M.D. Pp. 1257. Baltimore, Wm. Wood, The Williams & Wilkins Company. 1942. \$7.00.

This illustrated dictionary brings medical and scientific terminology up to date, thereby filling the need that arises from time to time. Quick reference is made easy by the bold type of the words to be defined, contrasted with the clear, well-spaced type of the definitions. Pronunciation, the origin of words and the "new nomenclature" appendix add to the value of the book.

SAMUEL BARBASH, M.D.



# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XV

November, 1942

No. 11

THE importance of the role of the general practitioner in the eradication of tuberculosis cannot be overemphasized. Mass programs of case finding in high schools, colleges, industry and racial groups are public health functions. But there are other categories that such drag-nets do not reach. One of these is the older third of the population. They constitute no single group to be rounded up for mass examination. Yet, they contain a higher percentage of infectious cases than any other age. The family doctor alone has direct access to this reservoir of community infection. To drain it effectively and speedily his aid is indispensable.

### UNDIAGNOSED TUBERCULOSIS IN ELDERLY PERSONS

Tuberculosis has been commonly considered a disease of youth. Its largest number of victims are post-adolescents and those of early middle life when super-infections most often occur. Many there are, however, who do not succumb to the disease nor yet eliminate the infection. As hosts to the tubercle bacillus they carry on an adjusted symbiotic existence which may reach into a green old age. The chronic cough attributed to "asthma" or "bronchitis" may actually be due to an indolent tuberculous process often accompanied by bacillary sputum. The menace of such occult cases to family and friends is obvious.

The detection of these cases is among the more baffling problems of a control program since experience has shown that it is difficult to obtain the examination of the elderly spreaders. They are naturally skeptical of the idea that they may be infected and often refuse examination through apathy or through fear that something may be found that would alter their customary manner of life. Commissioner Godfrey in a study of 17 counties in up-state New York found that in the cases studied 43% of the contacts under forty were examined, against only 14% of those contacts who were above that age.

"The best method of finding the elderly spreader of tuberculosis would seem to be the mass X-ray survey. Up to the present time, however, this method has not been used widely. Bloch has estimated that more than half the reports published on surveys in adults concern themselves with university students, hospital personnel and

student nurses. The majority of other surveys have been made on industrial and racial groups containing only a relatively small percentage of persons above the age of forty.

"Despite the fact that he is seldom discovered by any of the aforementioned methods of case finding, the relative frequency with which the elderly phthisic occurs in the population should make him of the greatest concern to those interested in tuberculosis control. Mortality figures for the United States, as prepared by Dublin, show that the highest death rate from tuberculosis occurs in males from sixty-five to seventy-four years of age, and in females seventy-five and over. Mortality statistics for New York City, prepared by Drolet, illustrate the fact that the decline in tuberculosis mortality since 1920 has been much greater in the young than in the old, particularly in males. The phenomenal decrease in tuberculosis among younger persons of New York City during this twenty-year period may very well reflect the efficiency of the methods used for its prevention, detection and treatment, while the high mortality of the elderly may partially be due to the fact that the same degree of emphasis has not been placed on the control of tuberculosis in this group."

At the Kips Bay-Yorkville Chest Clinic (New York City) a mass X-ray survey was made of 3,414 apparently healthy persons on home relief. The following table shows that the percentage of tuberculosis proved to be highest among those above 40 years of age.

Of the 100 clinically significant cases, 29 have

proved to be active on the basis of either (1) changes in the X-ray appearance of the lesions; either progressive or regressive, and (2) positive sputum.

Twelve of the positive-sputum cases found were over 50 years of age. None of these had marked symptoms at the time they were discovered and some have remained symptom free during a subsequent two years of observation. In such

"More emphasis should be placed on the examination of all possible sources of a newly diagnosed case of tuberculosis. Even when the older members of a tuberculous household appear to be in the best of health, they should be X-rayed. When a thorough search of the immediate family of an affected person fails to reveal the source of infection, further inquiries should be made as to the identity of others with whom he has most fre-

*Age and sex distribution of chronic and significant pulmonary tuberculosis*

AGE GROUP	MALES					FEMALES				
	Number Examined	Chronic Pulmonary Tuberculosis	Per Cent	Significant Pulmonary Tuberculosis	Per Cent	Number Examined	Chronic Pulmonary Tuberculosis	Per Cent	Significant Pulmonary Tuberculosis	Per Cent
15-19.9	133	0		0		134	0		0	
20-29.9	74	2	2.70	2	2.70	161	1	0.62	0	
30-39.9	192	11	5.73	5	2.60	314	9	2.87	5	1.59
40-49.9	257	30	11.67	17	6.61	347	17	4.90	6	1.73
50-59.9	365	44	12.05	22	6.03	418	35	8.37	10	2.39
60-69.9	350	50	14.29	17	4.86	450	49	10.89	8	1.78
70-79.9	116	20	17.24	5	4.31	84	9	10.71	3	3.57
80-84.9	9	2	22.22	0		10	2	20.00	0	
Total	1,496	159	10.63	68	4.55	1,918	122	6.36	32	1.67
Under 40	399	13	3.26	7	1.75	609	10	1.64	5	0.82
Over 40	1,097	146	13.31	61	5.56	1,309	112	8.56	27	2.06

cases reactivation may await some new strain such as an extra physical load imposed on the worker who enters war industry. This is a risk for the healed or arrested case as well.

"It is not known whether the higher incidence of tuberculosis in the elderly which we have encountered in a group of unemployed also occurs in elderly persons of higher income levels. Since mortality tables are prepared from deaths at all strata, it would seem possible that this may be the actual state of affairs. In any event, it is of the utmost importance to devote a greater portion of our efforts in tuberculosis case-finding to the discovery of the elderly individual with tuberculosis. This should be done without lessening case-finding measures in young persons, as the latter comprise a larger proportion of the population. Consequently, although the percentage of tuberculosis may be less in those of younger years, the absolute number of cases undoubtedly is greater.

quent contact, and examination of these persons should be arranged.

"The physician should also always suspect tuberculosis in all his elderly patients who have even mild pulmonary symptoms, and should take the necessary steps to rule out this disease before making a final diagnosis.

"The most productive method of case finding among the elderly would seem to be the X-ray survey of such population groups. The survey detailed in this paper serves to illustrate the value of such a procedure. Similar surveys concentrated on the older faction of the population, particularly males, would, we believe, disclose many unknown spreaders of tuberculosis who have been acting as reservoirs of disease in their communities."

*Undiagnosed Pulmonary Tuberculosis in Elderly Persons, Raymond E. Miller and Beatrice Henderson, Amer. Rev. of Tuberc., August, 1942.*

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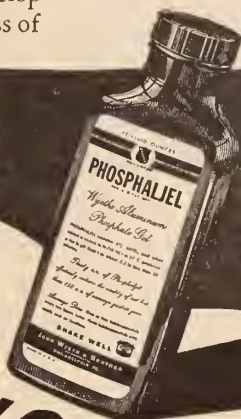
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<sup>1</sup>Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: *Aluminum Phosphate in the Therapy of Peptic Ulcer*, *Arch. Int. Med.* 67: 563-578 (March) 1941. \*Reg. U. S. Pat. Off.



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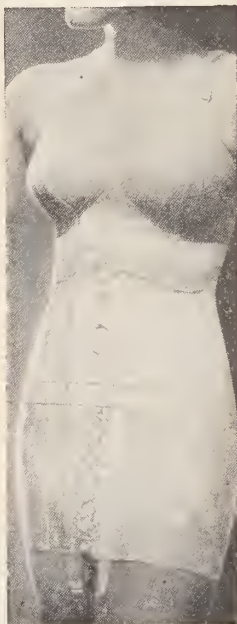
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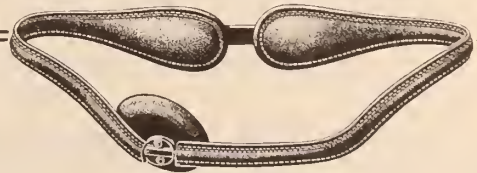
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### CONTENTS—Pages 615-676

#### EDITORIALS—

IN MEMORIAM—LEROY A. WILKES—1883-1942	615
PEACE ON EARTH GOOD WILL TOWARD MEN	616
GASOLINE AND THE M.D.	616

#### ORIGINAL ARTICLES—

THE ACUTE ABDOMEN IN INFANCY—Harrold A. Murray, M.D., F.A.A.P., Newark, N. J.	617
PUBLIC HEALTH IN WAR TIME—R. C. Williams, Senior Surgeon, U.S.P.H.S. Director, District No. 1, New York, N. Y.	619
THE TREATMENT OF ABORTION. Maternal Welfare Article No. 76—Arthur W. Bingham, M.D., F.A.C.S., East Orange, N. J.	624
A LESSON FROM A DEATH CERTIFICATE	629

EXECUTIVE OFFICER'S PAGE	630
--------------------------	-----

#### LEGISLATIVE NEWS—

Allocation of Physicians	631
Medical Care for Women's Army Auxiliary Corps	633
Annual Congress on Industrial Health	633

#### TIMELY TOPICS—

Program of Post-Graduate Course in Industrial Medicine and Hygiene	634
Standards for Maternity Care and Employment of Mothers in Industry	636
Clinico-Pathologic Conferences	637

#### STATE ACTIVITIES—

Letter to Members from the President and Chairman of the Finance and Budget Committee	638
Farm Security Medical Care Plan	638
Annual Conference of Secretaries and Editors	639
U.S.P.H.S. Reserve Commissions	641
Praise for Dr. Schlichter	642
Supplementary List of Members	643
Members Serving in the Armed Forces	643
Medical Care for Crippled Children	644

#### OBITUARIES—

Dr. John L. MacDowall	645
Dr. Barclay W. Moffat	645
Dr. Clifford R. Neare	645
Dr. Maurice L. Ripps	645
Deceased Physicians in New Jersey	645

BULLETIN BOARD	646
----------------	-----

#### COUNTY SOCIETY REPORTS—

Burlington, Cumberland, Gloucester, Hudson	647
Mercer	648
Middlesex, Monmouth, Passaic, Union	649
Warren, and N. J. Chest Physicians	650

WOMAN'S AUXILIARY PROGRAM 1942-1943	651
-------------------------------------	-----

THE BOOK SHELF	659
----------------	-----

TUBERCULOSIS ABSTRACTS	661
------------------------	-----

1942 INDEX (Volume 39)	663
------------------------	-----

Roster of Officers, Advertising Page 3a

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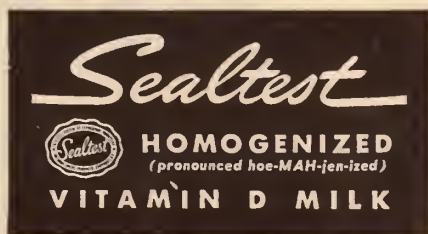
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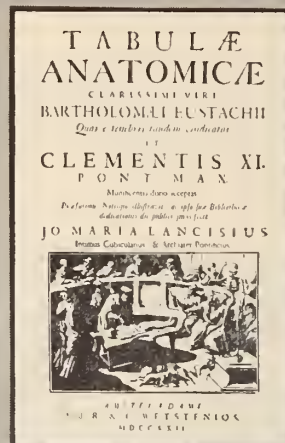
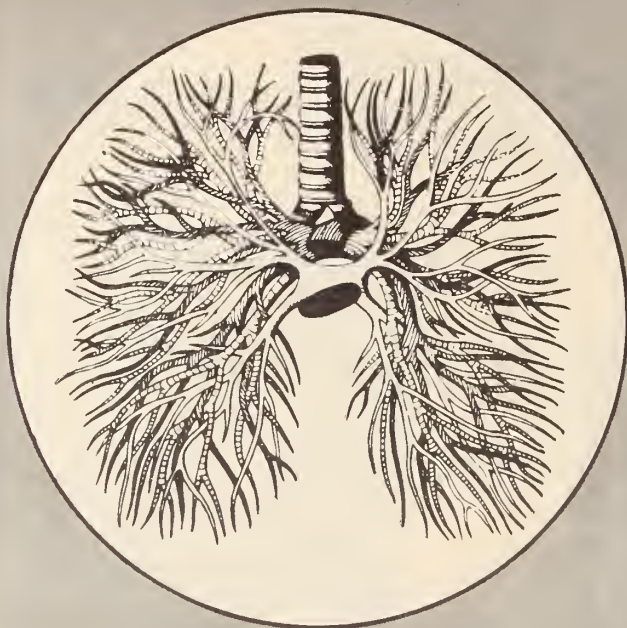
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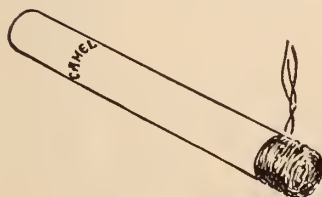
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Brückner, H.—Die Biochemie des Tabaks, 1936

The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

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Topical use of sulfonamides is assuming increasing importance not alone in military prac-

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\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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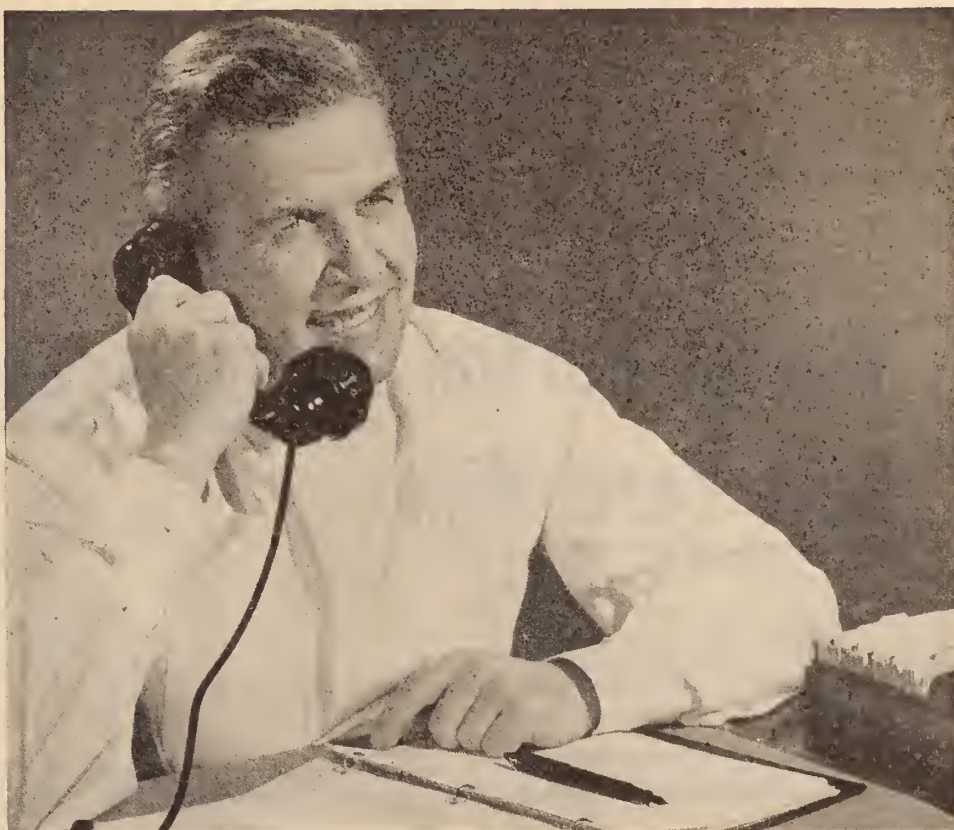
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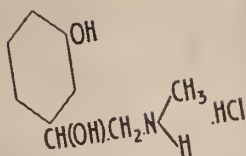
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## PEACE ON EARTH GOOD WILL TOWARD MEN

As Christmas approaches, we think of the aims for which we are now fighting, and they acquire a new and added significance. Every member of The Medical Society of New Jersey is united in the resolve to do his full part toward the realization of this ideal. Whether he can best serve in the Armed Forces, in industry, in civilian medical practice or in the Public Health Services, each can decide for himself, unless he should delay the decision too long and the government may decide for him.

The profession has already established its patriotism and its ability in its special field. Its humanitarianism, integrity and sincerity can best be judged in its daily activities and accomplishments. Prevention is its foremost aim — and this achievement is best assured when peace

and good will among men are established and maintained. In the light of the holocaust through which the world is now passing, only the strong and the brave can survive—but strength is not measured by brutality, nor is bravery measured by the criterion of *hara kari* or other forms of self-destruction. He is brave who gives his life in the fight that others may live to continue the struggle for the ideals for which he died.

Peace on earth will come to stay only when men are willing to keep themselves strong, brave and honest enough to fight for this ideal whenever and wherever it is attacked. There will always be some who are selfish and willing to provide the test.

The Man of Galilee probably chose one bad one among his twelve disciples to impress upon us this significant fact.

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## GASOLINE AND THE M.D.

Several County Society Bulletins have recently been urging their members to safeguard the profession and the nation against our enemies by avoiding any appearance of using gasoline and tires for other than strictly professional use. Where other means of transportation are unavailable, the use of a car for proper personal reasons is recognized as essential but it is believed that such need will not average more mileage than is provided for those who are given the A book of coupons by the Rationing Board and will not include pleasure trips. Physicians who confine their practice to the office are not entitled to preferred mileage under the prevailing ruling in cities. It is the intent to see that physicians get all gasoline

needed to carry out their professional work.

Tires and gasoline can be further conserved by a strict observance of the wartime speed limit of thirty-five miles per hour.

Physicians are leaders and moulders of public opinion in their communities. When others see that the physicians respect and obey the law, their example is most effective, since the public know that consideration is shown physicians by law enforcement agencies as a result of proven compliance with the law except in the rare instances when the saving of life itself is involved.

See The Journal of the American Medical Association for October 31, page 701.



## THE ACUTE ABDOMEN IN INFANCY \*

HARROLD A. MURRAY, M.D., F.A.A.P., Newark, N. J.

With the intention of acquainting the general practitioner, and the physician who confines his work to the care of children, with the more helpful methods of examination and the better preoperative and postoperative care of infants with an acute abdomen, the Pediatric Section of The Medical Society of New Jersey conducted a medical quiz on this important subject at the Annual Meeting in Atlantic City held in April, 1942.

As moderator of this quiz, I have endeavored to present herewith the many important facts brought out by the experts.

### CONGENITAL HYPERTROPHIC PYLORIC STENOSIS

This is the most common condition which requires surgical treatment in the first few months of life. The symptoms are those of high obstruction with accompanying loss of body fluids and chlorides. The vomiting generally occurs before the tenth day, is projectile in type, and contains no bile. With increasing vomiting, the stools become scant and the output of urine is lessened. Marked loss of weight occurs, and severe dehydration becomes evident.

The examination of the abdomen gives the greatest help in the diagnosis. The "tumor" should be 100 per cent palpable. Operation should not be resorted to unless the hypertrophied pylorus can be felt. It should be remembered that the infant must become quiet before a successful examination can be made. This can be accomplished by means of a pacifier or a small feeding of sweetened water. The stomach must be completely emptied, and a gastric lavage may be necessary. X-ray examination is not necessary for the diagnosis. Barium may be vomited and aspirated, and often distresses the infant postoperatively. When it is used only a thin mixture and a small amount should be given.

*Preoperative care.* A dehydrated infant should never be operated upon until lost body fluids and chlorides have been replaced. Sometimes this may take from two to four days. Subcutaneous routes, as by hypodermoclysis

with 5 per cent glucose in saline, either alone or, when possible, combined with an intravenous injection of 10 per cent glucose in sterile water, quickly relieve the dehydration. Transfusions are not advised before operation, and atropine sulphate has little value in the typical case of pyloric stenosis.

The *operation* described by Rammstedt is now generally employed to relieve this condition. Ether administered by the open mask drop method is the anesthesia of choice. The stomach is washed out before operation and some surgeons leave a 15 French catheter in place during the entire operative procedure.

*Postoperative care.* A routine feeding schedule somewhat along the following lines should be established: As soon as the infant is conscious, one ounce of fluid is given every two hours. This is continued for the first twenty-four hours, when regular feedings are instituted at three-hour intervals. Whenever possible, breast milk should be used. Barley water or a weak solution of evaporated milk and sterile water offers an excellent substitute. After the first week the infant is fed at four-hour intervals, with the daily requirement of fifty calories and three ounces of fluid per pound of body weight. It is often necessary to administer fluids parenterally during the first twenty-four hours, or as long as any signs of dehydration exist.

Infrequently an infant continues to vomit postoperatively. If this occurs and continues, further operative procedure might become necessary to relieve the obstruction.

### INTESTINAL OBSTRUCTION

Intestinal obstruction in infancy is due to either intrinsic or extrinsic causes. The intrinsic causes are: membrane, stenosis or atresias. Obstruction when caused by any of these offers a poor prognosis. The extrinsic causes are: bands, volvulus or fixation of the intestine in abnormal positions. The prognosis in these conditions is somewhat better.

\* Panel Discussion, Section on Pediatrics, The Annual Meeting of The Medical Society of New Jersey, April 22, 1942.

Congenital volvulus is the most common cause of intestinal obstruction. It is generally caused by the caecum and large intestines entering the umbilical opening first, instead of the small intestine which should precede it. This causes a torsion involving the mesenteric artery. The mesenteric artery supplies the small intestine as the prearterial segment, the caecum, ascending colon and one-half of the transverse colon as the postarterial segment. The prearterial segment should enter the umbilical opening first. If the postarterial segment enters first, then torsion of the duodenum around the mesenteric axis results with the formation of a volvulus.

A diagnosis of intestinal obstruction should be made *before* blood occurs in the stool. The suspicious symptoms of intestinal obstruction are: sudden intermittent colicky pain, *vomiting of bile soon after birth*, a mass in the abdomen and extreme shock.

The treatment is immediate operation with the preoperative measures to relieve dehydration. Ether with the open mask drop-method is the anesthesia of choice. The postoperative procedures to control dehydration and to re-establish feeding routines are the same as in other abdominal operations in infancy.

#### INTUSSUSCEPTION

Intussusception is one of the most important surgical emergencies in infancy. It is rarely caused by mechanical abnormalities in infancy and is more prone to occur around the fifth month of life. The symptoms are classical and should always suggest the presence of this condition. The little patient intermittently becomes pale and draws up his legs in extreme pain. Pallor, sweating, dehydration and shock followed by bloody stools occur within twelve hours. Abdominal and rectal examination reveal the presence of a sausage-shaped mass in a large number of cases. A barium enema examination is helpful in some cases, but the symptoms are so suggestive that a roentgenologic examination is rarely necessary to make the diagnosis.

The diagnosis of intussusception should be made *before* blood appears in the stool.

Nonoperative methods such as the colonic injection of air or fluids used in an attempt to reduce the intussusception, are to be condemned.

Postoperative treatment is very essential. Parenteral fluids should be administered about three times a day for the first four days, and only water in small amounts is given by mouth for the first twenty-four hours. It is unwise to give the full caloric intake of food before the end of the first week. Routine lavage both before and after operation will prevent vomiting, with resulting aspiration following operative procedures.

Postoperative peritonitis has been lessened with the introduction of a sulfonamide at the time of operation.

A postoperative fever is a common finding during the first few days after operation and, unless extremely high, is no cause for alarm.

If recurrence of intussusception takes place, which rarely happens, a second operation is immediately indicated.

#### SUMMARY

1. Congenital hypertrophic stenosis, volvulus and intussusception are the most common surgical conditions occurring in the first few months of life.
2. Success of the surgical procedure depends in large part on replacing the loss of body fluids, chiefly the chlorides, before the operative procedures are attempted.
3. Transfusions are rarely indicated preoperatively, and are only given postoperatively when indicated by the blood picture.
4. Roentgenologic examinations are rarely needed as an aid to diagnosis.
5. Ether given by the open mask drop-method is the anesthesia of choice, with the infant deeply narcotized.
6. Complete deflation of the stomach is essential before any anesthesia is administered.
7. A careful feeding routine used postoperatively, with the parenteral administration of fluids, insures success in most cases.

The experts who contributed so much to the success of this quiz were: Dr. Edward J. Donovan of New York City, Dr. Edward W. Sprague of Newark, N. J., and Dr. Irvin Deibert of Camden, N. J.

## PUBLIC HEALTH IN WAR TIME \*

By R. C. WILLIAMS, Senior Surgeon, U. S. Public Health Service Director,  
District No. 1, New York, N. Y.

At this time, the chief concern of public health authorities, whether Federal, State or local, is with the conservation and strengthening of the man-power of the nation. Important in peace, an aggressive public health program is a necessity for survival in time of war. The Public Health Service of the United States is directing its health defense efforts toward several objectives.

Broadly speaking, public health depends upon individual health. If a sufficient number of individuals in a given community are suffering from ill health, the public health of that community is accordingly affected. Thus, as a nation we are concerned with the individual health of the civilian population as well as the military forces. All of this together makes the public health of our nation.

Early in the defense effort, sometime before the United States was attacked by Japan, the Public Health Service recognized the need for reconnaissance sanitary surveys in order to acquire information that would be necessary in planning for military and industrial developments. Many communities are faced with the necessity of providing health and medical facilities for an influx of a large number of civilians. Many communities have grown and others will grow by 50 per cent or more, some have more than doubled in size. The migrating population have settled in some communities where facilities are relatively adequate. Others have invaded parts of the country where health and sanitary facilities may be described as primitive and of the sort that characterized the frontier boom towns of past generations. This does not mean that poor judgment has been used in the selection of defense areas, for military and tactical factors must sometimes outweigh health considerations in choosing a site for a camp or a munitions plant. It is our task to see that the health and sanitary needs in these areas are met as rapidly and as effectively as possible.

The new population in these areas is a

heterogeneous mixture. Many of them, of course, are industrial workers who have been drawn there by the prospects of employment in an industrial plant or on construction projects. Then, too, there is a great army of workers of one kind or another whose business it is to provide for the many different needs of the military personnel on leave and industrial or construction workers during their off hours—small merchants, waiters, bartenders, entertainers, and other persons. There are camp followers of various descriptions.

In many instances, the hopes of these people for employment or profit do not materialize, and they become a burden on the already overstrained community. Even though they can not pay for medical care, the health of the community demands that some provision be made for them.

The reconnaissance sanitary surveys conducted by the Public Health Service indicate that practically all defense areas are deficient in one or more of the essential facilities which they must have if they are to meet the demands imposed upon them by the emergency situation. Funds in addition to the present expenditures from all sources are needed in most communities to provide facilities for the following purposes: public health activities; hospital facilities; clinical facilities; medical care; housing; public water facilities; sewage disposal; garbage and trash collection and disposal; wells; mosquito and rodent control.

The value of sanitary reconnaissance work has been demonstrated. It is necessary that we have definite knowledge of the needs in various communities concerned in the war effort. With such information available action can be taken in the Washington Office on requests for assistance from the communities the day that such requests arrive. The surveys conducted by the Public Health Service in the various communities have proven of great value in

\* Presented before the General Medical Session, Tuesday afternoon, April 21, 1942—2:30-3:00 p. m.



passing upon the requests of communities for assistance.

The appropriation of funds by Congress has made possible a program of coöperative activities with state and local health departments whereby the facilities of the health department serving vital war effort areas could be supplemented or augmented by additional personnel and equipment furnished by the Public Health Service.

In order that the personnel employed by the Public Health Service under the emergency health and sanitation program might have the advantage of knowledge of the practices, procedures and policies of the Public Health Service, an orientation training course was established at the National Institute of Health of the Public Health Service at Bethesda, Maryland. All categories of professional personnel are required to attend this course of instruction, which consists of didactic work, demonstrations and field training activities. This orientation course usually lasts from four to six weeks. Medical officers, sanitary engineers, nurses and laboratory personnel have been recruited, trained, and assigned to state and local health departments for service in the war effort areas.

State health departments are invited to submit requests for personnel needed in areas concerned with war efforts. Insofar as available personnel permits, their requests are met. Personnel assigned to states for duty in National Defense areas are required to complete their field training by undergoing a period of orientation at the State Health Department for a period of a week or ten days in the State to which assigned. At the expiration of that time, they are assigned to vital war effort areas where additional aid is considered necessary. Personnel assigned in this manner to the State Health Departments are subject to the rules and regulations of the state and local health departments to which they are attached. The travel expenses of these personnel are provided by the respective states.

To date 116 physicians, 226 engineers, 145 public health nurses, 54 chemists and laboratory personnel have been trained and assigned to the States. In places where no local health

organization existed, a medical officer has been assigned to assist the State Health Department in setting up and operating an emergency health unit. In other areas where a local health department was in operation but could not meet its expanding responsibilities, the Public Health Service has augmented the existing staff. All of these employees are paid from Federal appropriations, but this vanguard of public health serves the state and local communities in exactly the same manner as the state health department's employees.

In the State of New Jersey, four physicians, one engineer, two public health nurses, and three chemists and laboratory technicians have been assigned by the Public Health Service to the State Health Department to supplement its regular staff in connection with the increased burden imposed by the war effort. They work under the direction of the State Director of Health, as do the other members of the State Health Department.

During the past six months, the Public Health Service has met the most acute needs in more than 150 war effort areas throughout the country. Within these regions are more than 900 separate communities, many of which for the first time are learning what it means to have professional, full-time public health services.

The responsibilities of the medical officers of the Army or Navy come when the tents or barracks of a cantonment are placed within an area and the military forces are moved in. But the responsibility for conditions outside the camp or cantonment does not rest upon the military authorities. It is not difficult to understand what transpire when a military city of 30,000 men is introduced into a civilian community of 3,000 persons. The military personnel are protecting the health of the troops, but what of the civilian population who suddenly find their town has grown to 40,000 persons?

For years many small communities have given little concern to their methods of getting rid of sewage and the system of handling water, and control methods against communicable diseases. The problem of overcrowding, with more people arriving daily, strikes the small

town's health facilities like an air raid, and soon overwhelms them. These towns need help from the Federal Public Health Service in two ways: financial and technical. They are receiving both.

In general, the Public Health Service priorities list rates safe water supplies and adequate sewage disposal first; health centers next; hospitals third; and public health laboratories fourth. It is also the general policy to erect these facilities only where the defense impact need is greatest. Any community where the war effort is in progress may obtain such Federal assistance if it can show that there has been sufficient impact of war effort upon the community. The community must first decide that it needs assistance. A request is then made to the Federal authorities for financial assistance for additional sanitary or hospital facilities. The Public Health Service verifies the need, and submits recommendations to the Federal Works Agency, and finally the determination is made and the allotment of funds is approved by the Budget Bureau and the President.

Now more than ever it is important to maintain the health of the industrial workers at a high level. Industrial mobilization relies on the productive capacity of the workers.

New industrial hygiene problems, including community sanitation, are centering around the concentrations of industrial workers in greatly expanded war industries. Added safeguards to the health of the war workers must be provided if this country is to secure the maximum war productive power.

In some localities, the entire population is dependent upon industry so that the health of the industrial workers in such areas forms an inseparable part of the health of the community. It is now generally conceded that if we are to advance in the development of physical and mental well-being among workers, we must pay attention not only to the working environment but also to factors associated with conditions outside of the place of employment. It is, therefore, obvious that the health of industrial workers is a matter of concern not only to industry but to the community at large.

Because of the pressure of longer hours,

overcrowding in the home, and other factors involved in the speeding up of the war effort, we must be particularly alert as to the health of our workers. The experience of the British indicates that we must be watchful for an increase in the tuberculosis rate, especially in young women in industry. We must, therefore, strengthen our efforts for the detection and control of tuberculosis. Our tuberculosis clinics, case finding services, and sanatoria are not to be discarded as a peace-time luxury. Human material must be conserved as carefully as supplies of important war supplies.

Definite plans must be made for emergency medical service in case of air raids or other enemy action along our shores. Medical officers of the Public Health Service assigned to the Office of Civilian Defense are developing emergency medical service plans in cooperation with the organized medical profession. Survivors reaching our shores from enemy action at sea on merchant vessels and convoys have brought sharply to our attention the need for providing temporary hospitalization and medical care for survivors and members of the families of survivors who require medical attention. The Public Health Service has plans in operation now to provide temporary medical care and hospitalization for persons residing in the United States, other than enemy aliens, who are (1) injured by enemy action; (2) dependants of civilians who are killed, disabled, interned or reported as missing; and (3) who are otherwise in need of assistance or services.

The examination of the first two million men under the Selective Service Act shows that approximately half a million were disqualified for any type of military service and another half million were eligible only for limited types of service. Many of these men, sorely needed now, would have been up to the fitness level if we had made stronger efforts during the years of the past to control the venereal and other communicable diseases; if dental care had been made available; if we had corrected the malnutrition of the underprivileged from the abundance of our food supplies; if we had extended medical care to those who needed it; and if we had applied to the full three-thirds of the population the

broad principles of sanitation and preventive medicine. The cost of doing this actually would have been less, State by State, than the cost of the physical rehabilitation with which we are now faced. This, however, is not the time to be concerned over lost opportunities but rather to make sure that we waste no more of them.

Having gone through a period in which we had an excess of man-power, a surplus of industrial production and a surplus of food, each of us in a varying degree have failed to foresee and to insist upon providing for this time of crisis; and now the problem of man-power, physical rehabilitation to the fullest possible degree of more than one-third of the selectees and volunteer who have been rejected for full military duty because of physical unfitness is an imperative first step. It has already been begun in a small way in one or two states for the border-line cases. Plans must be developed whereby the remediable defects of the rejectees can be corrected. All of us must make sure that similar defects are not allowed to accumulate in the generations now growing up. We must see that each citizen develops a maximum of strength and vigor and that every ounce of our total effort is put to the nation's use. This means more than medical and dental care. It means better nutrition through which we can add tremendously to the individual's health. It means the creation of a national psychology in which fitness is encouraged as a part of patriotism. The need for these qualifications, too, will be no less great after the war period.

A vigorous campaign for the control of the venereal diseases is another important factor in strengthening national health during the war period. In every war the venereal diseases have been a great drain upon military efficiency. We are much better prepared now than ever before to deal with this problem.

With Federal aid under the Venereal Disease Control Act of 1938 there are in operation more than 3,000 treatment centers and more than 2,000 diagnostic laboratories throughout the country. Each state distributes free drugs for all physicians for the treatment of their patients. As a part of the physical examina-

tion of each man under the Selective Service, a serological test for syphilis has been made. The state and city laboratories have done most of this work with Federal aid. Among the first million men examined, 48,000 cases of syphilis have been found. Of these, 3 per cent show clinical syphilis.

Treatment is important for the venereal diseases. Important steps have been taken in the direction of making better treatment available in each of the 48 states and in a large proportion of the cities. Great improvement has been made in the accuracy of public health laboratories, upon which we must depend for the diagnosis of a great proportion of cases and for checking up the progress of the treatment. Medical, nursing and technical personnel have been given special training at Federal expense and supplied to states and cities for venereal disease control work. Wherever control programs have been carried forward vigorously and consistently, there is evidence to show that syphilis is becoming less prevalent in the population and that the disease is beginning to recede.

Prevention is equally as important as treatment. Unless we wish to be forever bailing out the boat, we must stop the leaks.

According to a mass of factual evidence, the greatest source of venereal disease infection at this time is the professional prostitute. In spite of the fact that almost every state has laws to control commercialized prostitution, and similar ordinances are on the statute books of most cities, relatively few cities or communities consistently enforce these laws and tie them in with a public health policy of treatment, tracing of infections, and quarantine of recalcitrants.

A serious problem from the standpoint of public health work and of supplying medical care to the military forces and to the civilian population is the shortage of nurses. The Public Health Service has undertaken to meet this problem of a shortage of nurses. A program is under way to expand training facilities for nurses in the United States. More than 100 of the accredited nursing schools have increased their enrollment of student nurses by more than 2,000 with the help of Federal



funds. Other schools equipped for training more students have increased enrollment without help.

Fifteen thousand young nurses, previously inactive, are now available for return to duty. Refresher courses for more than 3,000 of these women have been established with Federal funds in more than 70 schools. We are told that the armed forces will continue to need nurses. There is an additional shortage of more than 10,000 nurses in civilian institutions. We have begun to train more nurses but the replacement program is still not making sufficient progress. This year and every year there is need to enroll 50,000 student nurses if this country is to have adequate nursing care. We are still 8,000 or more short of the mark.

The war in which we find ourselves engaged at the present time, and the resulting need for military and industrial mobilization, have not necessarily created new problems in public health, but the need has been intensified for the solution of old problems. Therefore, it is the work of state and local health departments, in coöperation with, and if necessary with, the financial assistance of the Federal Government, to augment existing facilities for the maintenance of necessary standards of health and sanitation.

This is the time for a united medical profession to work toward building our country's strength. We must fight with redoubled vigor against disease and disablement within our nation, in order that we may have the strength for victory against the enemy from without.

## HAZARDS OF THE MEDICINE CHEST IN BLACKOUTS ARE POINTED OUT

PHYSICIAN WARNS AGAINST DANGEROUS DRUGS IN POORLY MARKED OR MISLABELED BOTTLES THAT ARE TOO EASILY ACCESSIBLE

A blackout resulting from defense activities or normal electrical failure may bring needless loss of life if dangerous drugs in poorly marked or mislabeled bottles are too easily accessible, Austin E. Smith, M.D., Chicago, warns in *Hygeia, The Health Magazine* for November. "If the medicine chest is one of those places that has been ignored until you 'have more time', is not the present moment appropriate for a careful survey of the potential dangers?" he asks. "Perhaps your community may have practice blackouts before you have more time, unless you deliberately create that time.

"A systematic consideration of the pertinent points associated with the home medicine cabinet may easily obviate any attendant dangers. The cabinet should be out of reach of young children. Too often they find that they can easily reach their goal by climbing on the bathtub or washbasin. If the cabinet cannot be kept out of the reach of children it should be fastened securely by a lock, and the key to that lock should be kept out of the reach of children but in a nearby and readily accessible place—such as a hook on the top of the chest, beside the linen closet or behind the bathroom door. If no cabinet is provided in the bathroom, drugs and first aid agents may be kept

elsewhere but, above all, they should *not* be kept in the pantry along with articles of food.

"All bottles should be labeled so that there can be no mistaking the contents or the purposes for which they are intended. If possible, the labeling should permit accidental wetting without defacement of its statements. Any drug of a dangerous character should be kept on the highest shelf and not mixed with ordinary medicinal agents. \* \* \*"

"If poisons must be kept, they should not be in the regular medicine chest, but in a separate locked cupboard, and in containers which attract attention to their contents while being opened," Dr. Smith advises. "Boxes or bottles containing poisons should have their covers or corks fastened with adhesive tape, or pins stuck through the cork, to make the user stop and consider before using. If, in spite of all precautions, or because of the absence of precautions, poisons are taken, the following suggestions may help while the arrival of the doctor is awaited:

"Call the doctor at once when poison is suspected. Find out if possible what the patient has taken, so that the doctor may have some warning as to what to bring with him. At least give the doctor a brief and calm description of how the patient acts. \* \* \*"—*A. M. A. News.*

## THE TREATMENT OF ABORTION

### MATERNAL WELFARE ARTICLE NUMBER SEVENTY-SIX

By ARTHUR W. BINGHAM, M.D., F.A.C.S., East Orange, N. J.

A study of maternal mortality shows that nearly one-quarter of the deaths are due to abortion. One reason for this high mortality is that abortions are often treated too lightly until complications arise and the condition becomes serious. As most of the abortions are treated by the general practitioners this paper is meant to be of practical assistance to them in treating more successfully the many varieties of abortion.

Up to recent years an abortion was considered the interruption of pregnancy in the early months. Now it is defined as the termination of pregnancy before the 28th week of gestation when the foetus becomes viable. Treatment will vary a little depending on whether the abortion has occurred in the early months of pregnancy or later, up to 28 weeks, but the general procedure will be the same. Exceptions will be noted.

*In all varieties of abortion the two great dangers are infection and hemorrhage.* Extreme care must be taken to prevent infection, for in the great majority of cases the infection comes from without and is largely preventable. Active hemorrhage must be treated promptly and the need of transfusion must always be borne in mind. It has been found advisable not to use the patient's husband as a donor (unless the Rh factor has been found to give the same reaction on husband and wife) in these cases if donors can be found, for fear of serious reaction in some cases even though the husband's blood type matches.

The treatment of eight varieties of abortion will be considered:

1. Threatened abortion.
2. Inevitable abortion.
3. Complete abortion.
4. Incomplete abortion.
5. Septic abortion.
6. Therapeutic abortion.
7. Missed abortion.
8. Habitual abortion.

#### THREATENED ABORTION

When a woman who is pregnant a few weeks or months shows signs of vaginal bleeding with or without slight abdominal cramps, or occasional cramps without bleeding, prompt treatment is necessary to prevent an abortion.

The patient should go to bed at once and be given a sedative. A hypodermic injection of morphine,  $\frac{1}{4}$  grain, is the most effective treatment but many times the patient is some distance away or the physician cannot call at once. For these reasons a wise precaution is to order over the telephone two drams of paregoric repeated in an hour if necessary so that prompt sedation may be obtained until the physician can see the patient. Paregoric is used because it is the only preparation of opium which can be purchased by the patient without a prescription. It is a good precaution for every pregnant patient to have a little paregoric on hand for such an emergency. That it is of value has been proven many times.

Another preparation of value in quieting contractions of the uterine muscle is progesterone, which has often been found useful in preventing an abortion. However, it must be given by hypodermic injection and is not always at hand. It is repeated every two or three days until all symptoms of a threatened abortion have passed. Even though the cramps and hemorrhage have been severe, if they stop soon pregnancy may continue in certain cases.

If the cramps subside but there still remains a slight vaginal bleeding, the physician must decide whether the bleeding is due to a threatened abortion or to some other cause such as ectopic pregnancy, erosion of cervix, polypus of the cervix, hydatidiform mole, placenta previa, separation of the placenta, or cancer of the cervix.

After a week or ten days it will be safe to make a gentle examination with a speculum as well as bi-manually in order to rule out all of these conditions, if possible. A cervical polypus is the most common of these conditions but

it must not be removed at this time unless bleeding is marked for fear of causing an abortion. It may be painted with a mild astringent. The patient should remain in bed several days after all symptoms have ceased, then she can gradually get about and continue with her pregnancy.

#### INEVITABLE ABORTION

A threatened abortion becomes inevitable when: (1) the hemorrhage and cramps continue in spite of treatment, (2) the membranes rupture completely, (3) the cervix dilates to any extent, or (4) the ovum or foetus dies.

1. If the hemorrhage and cramps continue the patient should be hospitalized, if practicable. If possible, it is better to wait before packing the vagina until she reaches the hospital for fear of infection; however, if hemorrhage is severe or the patient is unable to go to a hospital, the vagina should be packed with iodoform gauze in the home, using all precautions to prevent infection. After twenty-four hours the packing may be removed and the products of conception will be found to be wholly or partly expelled into the vagina. The treatment will then be that of a complete or an incomplete abortion. Occasionally the contents of the uterus are expelled with such force as to push out the packing. The advisability of a transfusion must always be considered and donors should be available.

2. If the membranes rupture completely the pregnancy cannot continue. Sometimes a small amount of water leaks away from a cystic condition of the placenta or membranes and for a time acts like a complete rupture but stops without causing an abortion. If a true rupture occurs it is best to hospitalize the patient if possible and treat the case conservatively unless there is hemorrhage. If there is no hemorrhage it may be several days before there are any other signs of an abortion. In these cases it is better to wait until uterine contractions take place. The uterus then may completely empty itself and the case becomes one of complete abortion. If hemorrhage occurs while waiting for the uterus to contract or after the contractions begin, the vagina should be packed with iodoform gauze, using

all precautions. This packing may be left in place for as many as five days but as a rule the patient will soon begin to have pains as the uterine muscles contract. When the pains start, a mild sedative may be given but not in sufficient amount to stop the contractions. When the pains cease it will be time to remove the gauze packing, and the products of conception may be found in the vagina or cervix and can be easily removed. Then it is treated as a case of complete abortion. If the uterine contents are not completely passed, the case becomes one of incomplete abortion.

3. If the patient has cramps and the cervix becomes thinner and is dilated to any extent, an abortion is inevitable whether there is bleeding or not and the treatment is the same as that for a case with ruptured membranes.

4. If the ovum or foetus is dead, an inevitable abortion will occur. The contents of the uterus may be passed promptly, either completely or incompletely, or may remain several weeks or months as a case of missed abortion. The treatment for these different terminations will be considered under their respective classifications.

#### COMPLETE ABORTION

This is one in which the products of conception are completely passed; they are, as a rule, intact in the early cases. A dose of some preparation of ergot or pituitary extract may be given and the patient should rest in bed five or six days. After that she may gradually get up and about. There should be very little hemorrhage if the abortion is complete. In case of hemorrhage it means there is still something left in the uterus or else too much sedative has been given. If bleeding continues it is treated as in a case of incomplete abortion.

In cases of pregnancy of more than 18 or 20 weeks the treatment should be similar to that of a premature labor.

#### INCOMPLETE ABORTION

This is one of the most common varieties of abortion seen and often causes much trouble. The patient when seen has probably passed the foetus and possibly part of the placenta and is bleeding more or less. If possible, the patient



should be hospitalized and whether in the home or in the hospital every precaution should be taken to prevent infection. It is at the time of the first aid treatment that infection is apt to take place. It is a help to see and examine what the patient has passed but it is seldom saved in the excitement and frequently if saved is found to consist of nothing but blood clots.

Unless the bleeding is excessive it will not be necessary to pack the vagina before reaching the hospital. At the hospital, or in the home if remaining there, the vulva should be shaved and washed off with an antiseptic solution, and with a sterile rubber glove on, a vaginal examination should be made to determine the condition of the cervix. If the cervix is not dilated the vagina should be packed with two-inch iodoform gauze and the patient watched for 24 or 48 hours. She will then probably have a few pains and the cervix will dilate and the uterus can easily be curetted under light anesthesia. Of course it is not necessary to wait for the cervix to dilate but if the cervix is dilated artificially and a regular curettage attempted there is apt to be considerable hemorrhage and greater danger of complications.

If the cervix is already dilated and there is bleeding, the vagina should be packed with iodoform gauze while preparations are made for a curettage. The bleeding will be checked but not always completely stopped.

Frequently the patient states she has passed everything and on examination a piece of placental tissue is felt protruding from the cervix. This should not be removed until everything is in readiness for a curettage for fear of increasing the hemorrhage. If after packing the vagina the patient's condition is poor she should have a blood transfusion before anything else is done.

Many patients should be typed and donors procured so that if the patient's condition becomes worse following the curettage she may be promptly given a transfusion.

When it is time to curette the patient she should be taken to the operating room or placed on a table if at home, given a little anesthetic, and the uterus cleared out gently with a large, sharp curette. A broad curette should be used

for safety, since there is less danger of puncturing the uterus; and a sharp curette requires less pressure and more thoroughly clears out the uterus. A sponge forceps may be used if the placental tissue is protruding into or from the cervix, but to use it blindly inside the uterus is dangerous. Many times a roughened area in the wall of the uterus has been caught in the forceps and a hole made in the uterus and intestines even pulled down. A large, sharp curette is the safest instrument to use. A blunt curette is preferred by some but with this considerable pressure is necessary and even then pieces of adherent placental tissue are sometimes missed.

While the patient is being curetted a dose of one of the preparations of ergot or pituitary extract should be given by hypodermic injection to aid the contraction of the uterus. Morphine should *not* be given before the operation as it tends to delay this contraction. After the uterus is emptied it should be packed with iodoform gauze leaving a little gauze in the vagina. This procedure is a precaution against hemorrhage in case particles of placental tissue still remain and aids in stimulating contraction. If the uterus is properly cleaned out there will be very little bleeding.

The gauze is removed in 24 or 48 hours, depending on the stage of pregnancy. If the uterus is small, 24 hours is long enough to leave it, but if it is quite large, 48 hours is better. When it is removed a dose of some preparation of ergot is given to cause further contraction of the uterus. This treatment refers to cases of less than twenty weeks of pregnancy. After that incomplete abortion is less frequent and is terminated more like a premature labor.

There are some physicians who claim that most of the procedures in this method of treatment are unnecessary, that they seldom curette a patient, and rarely pack the vagina or uterus. It is the writer's belief that many of their patients convalesce slowly and some of them eventually turn up in some hospital where they are curetted and improved in health. There are some patients who do not get this far but die of complications. While undoubtedly some cases will recover if left alone, the treatment

for incomplete abortion as here outlined has been found to give better results with less morbidity and less mortality than any other treatment. It allows the patient to convalesce more quickly, gives less opportunity for subinvolution of the uterus, and lessens the danger of infection, hemorrhage, and death.

#### SEPTIC ABORTION

A septic abortion is one in which the uterus with its contents has been infected by some sort of manipulation either by the patient herself or another person. Rarely does the infection come from a focus within the patient. Some authorities classify cases as infected abortions or as septic abortions, the infected abortion being a mild infection and the septic abortion being a severe infection. A culture taken from the cervix may give important information as to the nature of the infection but it cannot always be relied upon.

The claim is made that the treatment may be different, being more radical in the mild infections and more conservative in the severe types. As it is not always possible at first to distinguish one group from the other, it is safer for the average practitioner to treat all cases of abortion having a rise in temperature as septic abortions. They should all be hospitalized at once if possible.

The treatment varies, depending on whether or not there is hemorrhage. In either case the patient should not at first be curetted on account of the danger of opening up avenues through which the infection is spread.

If an abortion case has a rise of temperature but has very little bleeding the treatment consists of rest in bed, plenty of fresh air and sunshine, and an ice cap over the lower abdomen. Some form of ergot or pituitary extract may be given as well as general supportive treatment and transfusions. Recently some of the sulfanilamide preparations have been used to advantage.

As a rule, the contents of the uterus will be expelled in two or three days, and if there is no hemorrhage the uterus is probably empty and no local treatment need be given unless the temperature remains above normal for 24 hours when the alcohol drain should be used.

If there is hemorrhage when the patient is first seen, or if it occurs during treatment, she should be taken to the operating room and given an anesthetic. Using all aseptic precautions the cavity of the uterus should be explored with the finger. If the cervix will not admit the finger it should be dilated. If a piece of placental tissue is found it should be removed carefully with the finger or sponge forceps but no curette used and then the alcohol drain inserted in the following manner:

A catheter is inserted into the uterus and iodoform gauze packed around it in the uterus and vagina. Through this tube two ounces of 25 per cent alcohol should be instilled every two hours day and night. After a few days the temperature generally drops and the tube and gauze are removed. The patient is then watched for ten days or two weeks and if temperature remains normal but a small amount of bleeding continues, she may be curetted with safety. This treatment, devised by the late Dr. E. J. Ill of Newark for the treatment of puerperal sepsis, is especially useful for septic abortion.

If this treatment is to be of value it must be carried out promptly and in every detail as described. If this is done before the infection spreads beyond the uterus, the results will generally be most satisfactory. Some operators, instead of using the catheter, pack the uterus with iodoform gauze soaked in 50 per cent alcohol and get very good results.

If the temperature still persists after four or five days, the catheter and gauze are removed and the patient is treated for a more general infection with transfusions, some preparation of sulfanilamide, and supportive treatment. Watch is kept for a local abscess in the pelvis which, if present, should be drained, through the vagina if possible. If infection is found to be in the blood stream the prognosis is very poor.

#### THERAPEUTIC ABORTION

A therapeutic abortion is one induced on account of some physical or mental condition of the patient which might result seriously for the mother or more rarely for the child, if pregnancy were allowed to continue. Consul-

tation and agreement with one or two physicians is necessary in these cases.

The method of procedure varies, depending whether it is done early or late in pregnancy. A therapeutic abortion should be done as early in pregnancy as possible. If the pregnancy is less than two and one-half months it is advisable to give an anesthetic and dilate the cervix and curette the uterus, then insert a little iodoform gauze into the uterus and vagina. This may be removed in 24 hours.

If the pregnancy is two and one-half months or longer, the following procedure is used: A large catheter or rectal tube is inserted through the cervix for almost its entire length and iodoform gauze packed into the vagina to hold the catheter in place. The gauze and catheter are left in place for several days until labor pains start, when a mild sedative may be given to relieve the patient, but the dose should not be sufficient to stop the contractions. Sometimes the gauze and catheter are expelled with the contents of the uterus. In other cases the pains cease and on removal of the gauze and catheter the products of conception may be found in the vagina and can easily be removed. If the uterus is only partially emptied it is treated like a case of incomplete abortion. If while still packed there are no pains after three days, some preparation of ergot or pituitary extract may be given in small doses. The case is then treated like an inevitable abortion as previously described.

Two errors are frequently made: (1) The gauze is removed too soon—it may be left in five or six days; (2) the preparation of ergot or pituitary extract is given too early—before the third day.

If the pregnancy is over 18 or 20 weeks it should be completed like a premature labor.

#### MISSED ABORTION

When the ovum or foetus dies in utero but is not expelled for some time, it is called a missed abortion. The pregnancy fails to develop and the uterus becomes smaller. There may be no signs of bleeding or of uterine cramps. This may continue for a few weeks or a few months.

The uterus after a time gradually contracts and finally expels its contents completely with

very little bleeding or incompletely with considerable bleeding. The treatment is then the same as for a complete or incomplete abortion.

Some authorities advise removing the contents of the uterus soon after the diagnosis is made in order to prevent infection. Others advise that while a very early pregnancy (less than two months) may be curetted safely, in the majority of cases it is better to wait and let the uterus empty itself. If there is no manipulation there should be no infection.

The writer is of this opinion and has never seen a case become complicated when so treated. In the effort to empty the uterus, some break in technic may cause the infection for which the dead foetus is blamed. There will also be less hemorrhage if the case is treated conservatively.

When the uterus has begun to contract, the expulsion of its contents may be hastened by a small dose of pituitary extract (M iii) or some preparation of ergot, but no local treatment is indicated unless there is hemorrhage or a partial expulsion of the products of conception, in which case the treatment would be that of an incomplete abortion. Recently it has been stated that some of the preparations of estrogen will bring about contractions of the uterus. How effective this is has still to be proven.

The prevention of missed abortion is very important for if the patient is not treated the condition will often recur. This preventive treatment is the same as that outlined for habitual abortion and if carried out carefully will give excellent results.

#### HABITUAL ABORTION

Patients with this condition are unable to continue with a pregnancy more than a few months. In some of these cases the foetus or ovum is still alive when expelled by an irritable uterus but more often it has died and is expelled as an abortion or a missed abortion. Sometimes this is due to the poor condition of the patient but more often she is apparently in good health. Sometimes the metabolism rate is low. A Wassermann test should always be taken, but as a rule this is negative.

The treatment of these cases is to search for some pathologic condition or focal infection and if found this must be treated. If nothing



abnormal is found, the patient must be put in the best possible health regarding nutrition and the nervous system. However, this alone is not enough, and if nothing more is done results will generally be disappointing.

Some of these patients need thyroid and most of them need iodine. The protoiodide of mercury in  $\frac{1}{4}$ -grain doses given once daily (always immediately after a meal) before pregnancy takes place and then twice daily throughout pregnancy will often give remarkable results. Even if unable to give it before pregnancy takes place its administration during pregnancy is most valuable. Some physicians prescribe iodine alone as Lugol's solution or the iodide of potash, but this form is difficult for some patients to take, and since the small amount of mercury in the protoiodide may also be beneficial in some cases, this drug is preferred by the writer.

The aromatic pill made by one manufacturer is less likely to disturb the digestive tract than other preparations. Good results have also been obtained by the administration of progesterone throughout pregnancy. This is quite an expensive treatment and has not been proven to be of more value than the use of some form of iodine, preferably the protoiodide of mercury.

#### CONCLUSION

It is evident that an abortion is a condition requiring serious consideration and should not be treated lightly. Complications are frequently caused by the wrong treatment. Not only is careful judgment required to determine the type of abortion present, but the symptoms must be watched as the case progresses in order to provide the proper treatment.

Many abortions could be prevented if the patient took less exercise in the first three months of pregnancy, avoided heavy house-

work (lifting or moving heavy objects), and did less automobiling, especially long trips.

The public should be taught, in an effort to reduce the number of induced abortions, that interference with pregnancy is dangerous. Induced abortions often cause chronic pelvic infection, sterility, and general debility, if not death.

When a history of missed abortion or of habitual abortion is obtained, treatment should be prescribed in order to prevent recurrence. The Rh factor in the blood has recently become a feature in the study of the incidence of habitual abortion and of missed abortion. The opinion has been expressed by some investigators that if the Rh factor reacts differently in the husband and wife there can be no healthy children. It is not certain that Protoiodide of Mercury will not in some cases influence the reaction of the Rh factor, or in some way make it possible to obtain a healthy living child. The writer has recently had a case in which the reaction of the Rh factor of the husband was positive and the wife was negative. Protoiodide of Mercury was given to the patient throughout pregnancy and a healthy normal living female child was born at term on November 3, 1942. The baby's Rh reaction is positive.

While it has been stated in this paper that the hospital is the best place to treat an abortion, all the procedures described here may be carried out in the home when necessary, provided competent assistants are available and proper precautions are used to prevent infection and to combat hemorrhage.

No attempt has been made to review the various methods of treatment suggested by different authors. The purpose of the paper is to give the general practitioner a clear outline of the treatment which has been proven by experience to be of value in each of the eight varieties of abortion.

144 Harrison Street

### A LESSON FROM A DEATH CERTIFICATE NUMBER FORTY-SEVEN

Patient, four months pregnant, aborted spontaneously after admission to hospital and had an immediate rise in temperature. *She was curetted*. Septic condition continued until she died.

Do not most of us agree that it is dangerous to curette a septic abortion? The alcohol drain is a much safer treatment for a septic condition of the uterus.

A. W. BINGHAM, M.D.

## EXECUTIVE OFFICER'S PAGE

### COMMITTEE MEETINGS

#### II.

##### COMMITTEE COMPOSITION AND PROCEDURE

The successful conduct of organized effort involves primarily a limited number of representatives who are chosen for their ability to make prompt decisions so that action can be begun at the earliest time, and accomplishment reached as soon as possible. There is little point to be gained by evading a decision which must finally be made.

Committee aims should be clearly stated, the immediate objective should be named and clearly written records of the procedure at each meeting should be provided. Committees are most effective when the number of members is small. Additional members can be added when and if necessary, but too many members often defeat the purpose.

The Chairman should carefully outline the scope of function assigned to the committee, otherwise there are complications resulting from overlapping of authority and effort, when responsibility is not definitely fixed.

A work program and schedule for its dispatch should be drawn up at the first meeting as a basis for discussion and planning. The conduct of the meeting should conform to the usual parliamentary procedure in order to insure accuracy at meetings and orderliness in procedure, and the conservation of time and effort toward the maximum accomplishment.

Plans should evolve out of the discussions of the committee members at the meetings, though they should be tentatively formulated in advance by the chairman to serve as a basis for discussion. It is essential that the Chairman conceal his own personal opinions, unless they are requested by the other members.

##### FREQUENCY OF MEETINGS

Next in importance to the care exhibited in the composition of the committee is the frequency of and thorough preparations for the meetings. Committees as a whole should meet only as frequently as the work demands, but much work can be done by the Chairman with the aid of selected individual members between meetings. The complete membership is necessary chiefly for final approval or disapproval of the proposals offered by the Chairman for the consideration of all the members.

When a committee has completed its assigned work it should be dismissed, or if a standing committee or subcommittee, should be recessed until a new problem is presented to it for solution. Nothing is more discouraging

to a competent committee member than to be continued on a supposedly active committee which never meets.

There are, of course, marked differences in the composition, procedure and scope of function to be noted in connection with the work of standing committees, subcommittees, advisory committees and special committees. The purpose and procedure of each type of committee should be clearly agreed upon after the presentation of the views of the Chairman regarding his committee's work. This point should be discussed at the first meeting of the committee.

Roberts' Rules of Order most generally govern procedure and can be studied with benefit by all who participate in group discussions. They contain the basic considerations. These can best be understood by putting through their application in practice.

In order to insure clarity in the discussions and in the minutes as taken by the stenographer, each member should proceed in an orderly fashion by addressing the Chairman and being granted the floor. When members address each other across the board without permission of the Chairman, not only is confusion caused but greatest accuracy in the recording of the minutes is made difficult, if not impossible.

##### TIME OF ADJOURNMENT

The wise Chairman uses the greatest discretion as to the time for adjourning a meeting of his committee. Ideally and ordinarily the meeting continues in session until the agenda is disposed of, but there are times when it is discreet to adjourn a meeting earlier.

Personalities should at all times be avoided and the discussions centered entirely upon the principles or points at issue. Appeasement, though desirable at all times, should never be obtained at the sacrifice of principle or the unnecessary delay of a decision urgently needed at the time.

None of the foregoing suggestions are intended to be dogmatic or unalterable. They do, however, constitute what experience has shown to be points on which efficient committee chairmen and members are in the main agreed upon, and are offered here for the sole purpose of aiding less experienced committee members to profit by the experience often gained at personal sacrifice by others.

## LEGISLATIVE NEWS

### ALLOCATION OF PHYSICIANS

The Subcommittee on Manpower of the Senate Committee on Education and Labor has submitted a report to the full committee with respect to the supply of physicians available to meet military, industrial and civilian needs. Senator Pepper of Florida is chairman of the subcommittee. Other members of this committee are Senators Hill of Alabama, Schwartz of Wyoming, LaFollette of Wisconsin and Millikin of Colorado. The report deals with a very important problem and for that reason it is here reproduced in full.

"This report is submitted at this time because of the need of speedy action to prevent an immediate peril to the health of the nation.

"Plain common sense persuades the committee to report its present information regarding the haphazard recruiting of doctors for the Armed Services. This unplanned recruiting has led us to a dangerous health emergency.

"The following facts are of paramount importance:

"1. A disjointed procurement policy in the military services, under which voluntary and involuntary induction occurs with various military units competing for the very limited supply of doctors available for war-time America. This has resulted in hoarding and freezing unused doctors in the American armed forces in a ratio double that of the British.

"2. Serious dislocation of medical manpower throughout the nation, because the ill-supplied rural areas are contributing twice and sometimes four times the proportion of doctors coming from urban areas. This uneven procurement threatens doctor famines in vast rural areas with the probability of a general epidemic similar to the influenza conditions of 1918.

"3. A tremendous unnecessary over-militarization of the doctor supply at the expense of the civilian population. Possibly this has been based on an inaccurate estimate of the number of doctors needed for a thousand soldiers and because in early 1942 the authorities responsible for obtaining doctors thought they were immediately required to produce a medical organization for a 13,000,000 man army.

"The conditions are so acute and dangerous that this preliminary report is made public with the recommendation that at the earliest possible moment the following steps should be taken: (a) The President, as Commander-in-Chief, should order a survey to be made of

over-supply and under-supply of medical personnel for both the armed forces and civilian needs. (b) A reallocation should be made wherever it is determined an over or under-supply exists. (c) Instruction should be given to the War Manpower Commission to cease its procurement drive for doctors in all states where quotas have already been attained.

"The armed services, the Federal government and the public should know now that certain states such as South Carolina and Oklahoma have produced from three to four times as many doctors for the armed services in proportion to peacetime supplies as states such as New York and Illinois. To permit patriotism to strip the rural areas and small cities of doctors in this haphazard manner is to invite epidemics, disease, and death. It is high time we put an end to the foolish and dangerous methods now employed to recruit doctors.

"There are three principal points to be made on the basis of testimony already received by this subcommittee. These points are:

"1. There exists today no adequate, overall, up-to-date picture of the manpower resources of this country or the use now being made of them in industry, agriculture, essential civilian services or the armed forces.

"2. Present policies for induction into the armed services, by draft or enlistment, are disrupting the war production program in industry and agriculture.

"3. The present policies for inducting a great volume of medical men into the armed forces and the lack of any adequate information on the military and civilian needs for medical service provide a dramatic example of the first two points.

"This subcommittee proposes that the allocation of doctors as between our armed forces and civilian use be made immediately on a nationwide basis. This experience can serve as a guide to the proper method of handling the nation's entire manpower resources.

"It is the committee's opinion that an overall civilian authority should be established at once to supervise and control the drafting and recruiting of doctors. Until this authority is actively functioning no recruiting of doctors for the armed services should be permitted.

"This authority should immediately conduct a census of all doctors, both those already serving in the armed forces and those still in civilian life. This census should be careful and



detailed. It should include a study of the distribution of physicians in civilian communities so that we may know at once what are the minimum needs of each area for medical care and whether these needs are now fully met, over-supplied or under-supplied in both optimum and minimum terms. We should have firmly fixed in mind the irreducible minimum of medical care needed to prevent disease and epidemic in civilian America, including war plant areas.

"From information presented to the committee it appears that prior to the induction of doctors into the armed forces the national average was about one doctor for every eleven hundred individuals. In one of our large southern states that ratio has now been reduced to one doctor for more than seventeen hundred persons.

"Quotas were fixed by the Procurement and Assignment Service for every state. The combination of draft and recruiting team activity has removed in certain Southern States nearly 200 per cent of the quota while in certain Northern States less than 50 per cent of the quota has been inducted. In some counties in the Southern States, hitherto fairly well supplied with physicians, there is now only one doctor for seven thousand individuals. It would appear that the nation has been fortunate to have avoided serious local or even national epidemics to date.

"If the information supplied this committee is accurate, approximately one-third of the medical effectives of the country are now in the armed forces. According to information received by the committee, the military services desire to maintain their present ratio of approximately one doctor for every 100 men in service.

"If we take the figures recently stated by Secretary Stimson of a 7,500,000-man army in 1943 and allow for over a million in the other armed services by that time, we arrive at a figure of 85,000 doctors in the armed services out of a probable total of 120,000 effectives available in this country at the start of the induction program. The present total induction works out at one doctor now in the armed forces for every three effectives.

"If the present ratio of doctors to men in service is maintained we shall have two out of three doctors in military service in 1943 and an average of one doctor for every 3,000 or more civilians, or less than one-third of our entire medical effectives available to provide medical service to the civilian population including our war plants.

"Clearly we cannot afford further haphazard

induction and recruiting of medical personnel.

"The over-all authority proposed above should ascertain the use now being made of medical personnel in the armed services as compared with their professional qualifications. The committee has received testimony that indicates the professional skill of doctors in uniform is not being properly utilized.

"It has also been indicated that the ratio between military personnel and doctors in the service is more than twice that maintained in the military service of our Allies. The authority should study British experience and work out with the military forces a balanced plan for use of this scarce national resource.

"This authority should then set up a plan whereby all further induction of doctors into the armed services operates as an orderly withdrawal which will not cripple the medical services of any community or permit epidemics to spread from areas of inadequate medical care.

"The committee believes that this startling situation in America's medical services requires immediate attention. We also believe that the treatment accorded this situation can afford us a splendid opportunity for demonstrating methods to be applied to the nation's entire manpower mobilization. It is for this reason that the committee urges the immediate establishment of an over-all authority and itself proposes to hold hearings on ways and means for the creation of such an authority.

"The committee will follow this preliminary report with hearings to which it will call qualified representatives from the medical profession and laymen who are officially connected with the present system of Procurement and Assignment of medical personnel now attached to the War Manpower Commission. Both civilian and military authorities will be heard.

"The committee will pursue two further inquiries in the immediate future. The first will consider the means of securing an adequate nationwide census of available manpower and womanpower. The committee has heard testimony from the Director of the Census, Mr. J. C. Capt, and his assistant, Dr. Philip Hauser, on the need for a five per cent sample census to be taken immediately so that we may bring up to date the statistical materials of the 1940 census. Induction into the armed forces and large scale population movements to war production jobs have greatly altered the population distribution shown in that census. Even within communities great shifts in employment have occurred. There are large rural areas which will require planned transfer of their working population if the labor in those areas

is to be effectively used in war production either in industry or agriculture. An up-to-date basis for such a transfer program is badly needed. Similarly many women not hitherto in the labor market must be trained for war work.

"This committee advocates a sample census but wishes to hear testimony on this and alternative proposals. We hope that an early start may be made on a nationwide enumeration of our manpower supply.

"The committee has also heard testimony on the present inadequacy of occupational deferment machinery operated by the Selective Service System. This will be the second inquiry in the immediate future.

"The committee is satisfied that within the last few months large numbers of skilled war production workers have either been inducted or pressed to enlist in the armed forces when they should have been retained in our war industries and agriculture.

"It seems clear that the nation's war production goals cannot be met without a careful husbanding of America's skills. The commit-

tee has featured in this preliminary report the problems of inducting doctors because medical training is one of our least replaceable skills. The time required to train a doctor for active practice outruns any span of war years which we should now contemplate. Our existing supply must be regarded as virtually our total supply for the duration of the war.

"The committee believes that a nation-wide system of occupational deferment boards must be devised to follow close on the heels of a genuine planned program of medical mobilization.

"The principle should be established that the nation intends to use its critical skills where they can be most useful towards winning the war.

"By an adequate program and effective machinery for the appraisal of need and use of the nation's manpower, much can be accomplished at an early date without resort to compulsory measures."

A report of the hearings held before the subcommittee appears in the November 21, 1942, issue of the A. M. A. Journal, pages 927-967.

## MEDICAL CARE FOR WOMEN'S ARMY AUXILIARY CORPS

H. R. 7673, introduced by Representative Rogers of Massachusetts, October 8, and pending in the House Committee on Military Affairs. A bill to provide medical and hospital treatment and domiciliary care for members of the Women's Army Auxiliary Corps on a parity with members of the Women's Reserve of the Navy.

*Comment*—As indicated, this bill provides that active duty as a member of the Women's Army Auxiliary Corps shall be considered as active military service for the purpose of medical and hospital treatment and domiciliary care under laws administered by the Veterans' Administration.

## ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The fifth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will be held Monday, Tuesday and Wednesday, January 11-13, 1943, at the Palmer House in Chicago. These meetings are open to physicians and others interested in industrial health. There is no registration fee.

A symposium on Infections in Industry will be conducted jointly with the Council on Pharmacy and Chemistry to include not only those of definite occupational origin but also others causing serious loss of time in industry, notably those affecting the upper respirator system.

Another session of the congress has been assigned to industrial medicine and the emergency.

There will be symposiums on Medical Relations in Workmen's Compensation, jointly presented with the Bureau of Legal Medicine and

Legislation, and on Recent Developments in Rehabilitation, presented jointly with the Council on Physical Therapy.

On the last day a round table on Nutrition of Industrial Workers will be held in company with the Council on Foods and Nutrition and interested personnel from the National Research Council and the United States Public Health Service. Directly following this symposium a conference on industrial health to which the public will be invited will be held under the joint auspices of committees of the Chicago Medical Society and the Illinois Manufacturers' Association.

An exhibit is planned which will demonstrate the industrial health services now available through agencies in organized medicine, public health and a few independent agencies.

The program appears on page 1145 of the A. M. A. Journal for December 5, 1942.

## TIMELY TOPICS

### PROGRAM OF POST-GRADUATE COURSE IN INDUSTRIAL MEDICINE AND HYGIENE

to be presented under auspices of

Committees on Industrial Health of the Philadelphia County Medical Society and  
the Medical Society of the State of Pennsylvania

Directed jointly by the

Departments of Preventive Medicine and Public Health of the University of Pennsylvania and the Woman's Medical College of Pennsylvania at the Philadelphia  
County Medical Society

Preliminary Mass Meeting: Wednesday evening, December 30, 1942, 8:30 P. M.  
County Medical Society Building.

Preceded by: Subscription Dinner at 6:30 P. M.

The cost of the full course is \$25.00, or \$5.00 for each single week taken.

#### FIRST WEEK OF INSTRUCTION

January 5, 7 and 9, 1943

##### GENERAL PROBLEMS

Tuesday, January 5, 1943, 4-6 P. M.

- I. Organization and Set-Up of Medical Services in Large Plants.
- II. Bringing Health Supervision to the Small Plant.
- III. Keeping of Records.\*

##### THE WORKER AND THE JOB

Thursday, January 7, 1943, 4-6 P. M.

##### Evaluating the Worker

- I. The preemployment examination.\*
  - a. Need for examination (male, female)
  - b. Scope of examination (male, female)
  - c. Classification on a physical health basis
- II. The neuro-psychiatric examination and tests:
  - a. Mental appraisal: special tests.  
Natural intelligence, trainability, adaptability to group activity, etc.
  - b. Neurological evaluation  
Muscular coordination  
"Tempo" of the worker  
Adjusting the neurologically handicapped.
- III. Placement Criteria.
- IV. The Periodic Check-up.

\*A display will be presented of recording and filing equipment and examination forms in use by several firms.

Saturday, January 9, 1943, 4-6 P. M.

- I. Factors Influencing Health and Efficiency of Worker.
  - a. Temperamental adaptability to work.
    1. Borderline mental hygiene cases.
    2. Worry, etc.
  - b. Socio-economic factors.
  - c. Racial factors.
  - d. Age and sex.
- II. Minor illness and functional disturbances.
- III. Absenteeism.

#### SECOND WEEK OF INSTRUCTION

January 12, 14 and 16, 1943

##### LEARNING THE SCOPE OF THE FIELD

Tuesday, January 12, 1943, 4-6 P. M.

- I. Use of Official Surveys of Industries or Industrial Areas to Learn the Hazards Involved.
- II. The Plant Survey and Inspection
  - a. Plant Sanitation.
  - b. Process and General Hazards and Efficiency of Preventive Measures and Their Use.
  - c. Observing the worker "on the job".

Thursday, January 14, 1943, 4-6 P. M.

- I. Correlated Services Engaged in Health Supervision.  
Scope, limitations and interrelations of work of:
  - a. The Personnel Director
  - b. The Medical Director
  - c. The Safety Director
  - d. The Industrial Nurse
  - e. The Social Service Worker

Saturday, January 16, 1943, 4-6 P. M.

- I. Qualities of a Good Medical Director
- II. Merging of Non-Medical Interests in Maintenance of Health and Efficiency of the Worker.
  - a. Its Value to Management and Production
  - b. Organized Labor's Interest and Cooperation
  - c. The Insurance Underwriters' Responsibilities
 Visits to large and small plants will be arranged for those wishing to see those services in action.

#### THIRD WEEK

January 19, 21 and 23, 1943

##### PHYSICAL FACTORS

Tuesday, January 19, 1943, 4-6 P. M.

##### Physical Factors Affecting Health

- I. Effects of Inadequate Ventilation
  - a. General Effects
  - b. Specific needs of industrial processes
  - c. General methods of control
- II. Excess Thermal Hazards  
Heat Prostration and "Heat Sickness"
  1. Industries where encountered
  2. Preventive methods and control
  3. Disability resulting
- III. Effects of Noise and Vibration
  1. Industries where encountered
  2. Preventive methods and control
  3. Disability resulting

Thursday, January 21, 1943, 4-6 P. M.

##### Extremes of Air Pressures

- I. Caisson or Tunnel Disease, its causes, prevention and results
- II. Aviation hazards of altitude and cold

Saturday, January 23, 1943, 4-6 P. M.

- I. Fatigue in Industry
- II. Nutrition in Industry



# FOURTH WEEK

January 26, 28 and 30, 1943

Tuesday, January 26, 1943, 4-6 P. M.

- I. General Safety Measures in Accident Prevention
- II. The Work of the National Safety Council
- III. Protective Devices  
(Display and demonstration of various safety devices will be arranged.)

Thursday, January 28, 1943, 4-6 P. M.

- I. Minor Accidents and Their Care.
- II. The First Aid Trained Worker
  - a. Where he is of value
  - b. His limitations
- III. Burns and Scalds

Saturday, January 30, 1943, 4-6 P. M.

- I. Fractures and Crushing Injuries
- II. Newer Methods in Traumatic Surgery
- III. Rehabilitation of the Injured

# FIFTH WEEK

February 2, 4 and 6, 1943

Tuesday, February 2, 1943, 4-6 P. M.

- NON-OCCUPATIONAL DISEASE HAZARDS IN INDUSTRY
- I. Venereal Disease in Industry
  - II. Dermatitis and Dermatoses in Industry
  - III. Carcinogenic Substances Used in Industry  
Tar and compounds  
Radium and x-ray, etc.

Thursday, February 4, 1943, 4-6 P. M.

- I. Upper Respiratory Infections and Their Effect on Worker and Work
- II. Hazards of Exposure to the Elements
  - a. Pneumonia
  - b. Rheumatism, neuritis, myositis  
(Extent, where encountered in industry and how controlled.)
- III. Cardio-Vascular Conditions Affecting and Effected by Industry (including alcoholism)

Saturday, February 6, 1943, 4-6 P. M.

- I. Tuberculosis in Industry  
*Dust Hazards*
- II. The Pneumoconioses
  - a. Minor Organic and Inorganic Dust Hazards
  - b. Silica and Silicates
    1. Asbestosis
    2. Silicosis and Silico-Tuberculosis
- III. Dusty Trades: Pottery making, granite cutting, sandblasting, etc.  
(Display of portable x-ray equipment and case-roentgenograms.)

# SIXTH WEEK

February 9, 11 and 13, 1943

Tuesday, February 9, 1943, 4-6 P. M.

## TOXICOLOGY

- I. General discussion of toxicology and classification of toxic substances on basis of absorption and reaction on the worker
- II. Metallic Poisoning \*
  - a. Lead
    1. Forms encountered in industry and their action
    2. Trades and processes where encountered
    3. Prevention and control measures

Thursday, February 11, 1943, 4-6 P. M.

- I. Metallic Poisoning (continued) \*

- b. Chromium and Cadmium
- c. Mercury and Zinc, etc.
- d. Selenium and Vanadium
- e. Manganese and Magnesium
- f. Antimony, Copper and Tin
- g. Arsenic, etc.

## II. Metallic Fumes and Gases

- III. a. New use of these substances and their hazards  
Ex.: Synthetic rubber (magnesium-explosive hazard)
- b. Special processes causing metallic hazards.  
Welding  
Plating, etc.
- c. Metal Fume Fever

Saturday, February 13, 1943, 4-6 P. M.

- I. Acids, Alkalies, Alcohols, Esters, Aldehydes, etc.
- II. Vehicles, Solvents, Cleansers and De-greasers  
\*(Nature of action and injury)  
(Industries and processes involved)  
(Prevention and control)

# SEVENTH WEEK

February 16, 18 and 20, 1943

Tuesday, February 16, 1943, 4-6 P. M.

- Some of the More Complex or Hazardous Industries. Panel
- I. Silicious Trades—Pottery Manufacturing, Granite Cutting, Mining, Sandblasting, etc.
  - II. Lead Trade—Salts of lead, storage battery manufacturing, paints and rubber manufacturing, lead as an alloy, etc.
  - III. Cleaning, dyeing and processing (benzol, benzene derivatives, degreasers, etc.)
  - IV. New coatings, etc. (enamels, ducos, etc.)
  - V. Automotive Industries—Lead coatings, welding, carbon monoxide, etc.
  - VI. Synthetics—Plastics, textiles, etc.
  - VII. Manufacturing and use of insecticides and disinfectants.

Thursday, February 18, 1943, 4-6 P. M.

- The Specialties in Industries
- Ophthalmology—Eye Hazards and Preservation of Sight
- Otology—Vibration and Noise and Preservation of Hearing
- Neuro-psychiatry (as applied to the individual worker)  
Early signs and diagnostic tests for accumulative toxic effects, etc.
- New Aspects Due to War  
Tuberculosis, gynecology and obstetrics in women workers  
Earlier tuberculosis, toxic effects, etc., in youth.

Saturday, February 20, 1943, 4-6 P. M.

- I. Changes in industry due to war, presenting special hazards
  - a. General aspects in plant processes; Speeding-up; rapid turnover; overtime; continuous production; mixed personnel; special training, etc.
  - b. Changing processes and practices affecting health; "assembly line" specialization and its effect on the worker; the three-shift day; mass production techniques; spray gun painting; sand-blasting; automatic drilling, electric welding, etc.
- II. Special problems presented by new employee groups (panel)
  - a. The militarily unfit
  - b. The returning older worker

- c. Women in industry
- d. Safeguarding youth

### EIGHTH WEEK

February 23, 25 and 27, 1943

#### COMPENSATION AND MEDICO-LEGAL FACTORS

Tuesday, February 23, 1943, 4-6 P. M.

- I. Extent and Result of Accident Compensation
- II. Extent and Trends in Occupational Disease Compensation.

Thursday, February 25, 1943, 4-6 P. M.

- I. The Compensation Boards

- II. The Expert Medical Witness, His Responsibilities and His Limitations

#### III. General Medico-Legal Aspects

Saturday, February 27, 1943, 4-6 P. M.

Orientation of Medical Efforts for Health Supervision in the Future.

- a. The rôle of the Public Health Department
- b. The Private Practitioner's Responsibility and Opportunity for Maintenance of Health.
- c. Organized Medicine's Rôle
- d. Hospital and Medical Service Insurance Now and in the Future

## STANDARDS FOR MATERNITY CARE AND EMPLOYMENT OF MOTHERS IN INDUSTRY

Prepared by the Children's Bureau and the Women's Bureau of the U. S. Department of Labor. Submitted by Committee on Care of Mothers and Children, Newark Defense Council.

### GENERAL STATEMENT

With increased employment of women in industry, the problem of protection of the pregnant woman and her child has become more urgent. Many inquiries have come to the Women's Bureau and to the Children's Bureau from a variety of sources, such as employers, workers and health departments, concerning the types of work suitable for pregnant women and the policy of maternity leave. The labor situation in this country does not necessitate the recruitment or employment of pregnant women or women with infants. A woman who is expecting a child should give first consideration to her own health and to plans for safeguarding the health and care of the child. Because some women who are pregnant or who have young children may find it necessary to work, the following statement of policy has been formulated to serve as a working basis for those concerned with this problem. It is recognized as a general policy that provisions for maternity care and leave should not jeopardize the woman's job or her seniority privileges.

### EMPLOYMENT POLICIES AND CARE FOR PREGNANT WOMEN

These recommendations are based on the premises that, to safeguard the pregnant woman who works, certain special provisions should be made. She should have opportunity for adequate antepartum care. She needs sufficient time off before delivery to allow her to be in a rested state at the time of delivery and to prevent undue strain in the latter part of pregnancy. If she is employed in certain occupations that involve hazards or strain, or if

complications of pregnancy occur, she needs special consideration. The wide variation in general physical condition and in the amount of home duties performed outside working hours necessitates some individualization of arrangements for maternity leave and protection.

The following general recommendations are made as a guide:

1. Facilities for adequate antepartum medical care should be readily available for all employed pregnant women, and arrangements should be made by those responsible for providing antepartum care so that every woman will have access to such care. Local health departments should make available to industrial plants the services of antepartum clinics; and the personnel management or physicians and nurses within the plant should make available to employees information about the importance of such services and where they can be obtained.

2. Pregnant women should not be employed on a shift including the hours between 12 midnight and 6 a. m. Pregnant women should not be employed more than eight hours a day or more than forty-eight hours a week, and it is desirable that their hours of work be limited to not more than forty hours a week.

3. Every woman, especially a pregnant woman, should have at least two ten-minute rest periods during her work shift, for which adequate facilities for resting and an opportunity for securing nourishing food should be provided.

4. It is not considered desirable for pregnant women to be employed in the following types of occupation, and they should, if pos-

sible, be transferred to lighter and more sedentary work:

a. Occupations that involve heavy lifting or other heavy work.

b. Occupations involving continuous standing and moving about.

5. Pregnant women should not be employed in the following types of work during any period of pregnancy but should be transferred to less hazardous types of work:

a. Occupations that require a good sense of bodily balance, such as work performed on scaffolds or stepladders, and occupations in which the accident risk is characterized by accidents causing severe injury, such as operation of punch presses, power driven woodworking machines or other machines having a point of operation hazard.

b. Occupations involving exposure to toxic substances considered to be extra hazardous during pregnancy, such as:

Aniline.

Benzene and toluene.

Carbon disulfide.

Carbon monoxide.

Chlorinated hydrocarbons.

Lead and its compounds.

Mercury and its compounds.

Nitrobenzene and other nitro compounds of benzene and its homologues.

Phosphorus.

Radioactive substances and x-rays.

Turpentine.

Other toxic substances that exert an injurious effect on the blood-forming organs, the liver or the kidneys.

Because these substances may exert a harmful influence on the course of pregnancy, may lead to its premature termina-

tion or may injure the fetus, the maintenance of air concentrations within the so-called maximum permissible limits of state codes is not, in itself, sufficient assurance of a safe working condition for the pregnant woman.

Pregnant women should be transferred from workrooms in which any of these substances are used or produced in any significant quantity.

6. A minimum of six weeks' leave before delivery should be granted, on presentation of a medical certificate of the expected date of confinement.

7. At any time during pregnancy a woman should be granted a reasonable amount of additional leave on presentation of a certificate from the attending physician to the effect that complications of pregnancy have made continuing employment prejudicial to her health or to the health of the child.

#### EMPLOYMENT POLICIES AND CARE FOR THE MOTHER AND INFANT AFTER DELIVERY

To safeguard the mother's health she should be granted sufficient time off after delivery to return to normal and to regain her strength. The infant needs her care, especially during the first year of life. If it is essential that she return to work, the following recommendations are made:

1. All women should be granted an extension of at least two months' leave of absence after delivery.

2. Should complications of delivery or of the postpartum period develop, a woman should be granted a reasonable amount of additional leave beyond two months following delivery, on presentation of a certificate to this effect from the attending physician.

## CLINICO-PATHOLOGIC CONFERENCES AT THE NEWARK CITY HOSPITAL

With the cooperation of the Hospital Staff and under the fine leadership of Dr. Harrison Martland, the bi-weekly clinico-pathologic conferences at the City Hospital are now under way for the coming year. The first one was on November 24th. These meetings are at 9 o'clock on the second and fourth Tuesdays of each month. They constantly strive to be of general interest to the profession. An effort is made not only to present diagnostic and therapeutic problems, as thoroughly studied as possible and embracing all the specialties, but

also, in succeeding meetings, to follow-up selected cases. Experience has shown that lively and stimulating discussion is very often provoked.

From his vast experience as Pathologist to the Hospital and as Essex County Medical Examiner, Dr. Martland is able to present in a uniquely satisfactory manner, through the agency of the epidiascope, fresh pathologic specimens pertinent to the clinical material at hand as well as other items of medical interest via his large collection of Kodachromes.

Everyone is cordially invited.



# STATE ACTIVITIES

To the Officers and Members of the County Medical Societies:

Each member is fully aware that a large portion of our membership is serving in the Armed Forces of the Nation, and that the House of Delegates has approved the remission of the assessment annually made on the county societies for those members who are on active duty. Most or all of the county societies have also cancelled their membership dues. This procedure causes the financial burden of both the state and county societies to fall entirely on those members who remain at home, a burden which becomes increasingly heavy as the accumulated reserves of former years (where such exist) disappear, and an increase in dues seems inevitable for 1943. It is pertinent to point out that the total income to doctors has not decreased, since the former income of those now serving in the Armed Forces has been distributed among those who remain at home. In view of this increased return to the remaining members at home, it should be no hardship upon them to contribute an extra assessment of ten or fifteen dollars to make it possible to continue to exempt from the payment of dues, our members in service.

Please consider these facts so that if it becomes necessary to increase the dues you will have a clear understanding of the underlying reasons.

Fraternally yours,  
ELIAS J. MARSH, M.D., President  
HARRY R. NORTH, M.D., Chairman,  
Finance and Budget Committee.

## MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY FARM SECURITY MEDICAL CARE PLAN—1939-1942

### HISTORY—1939

The Farm Plan was first operated on a county basis in Atlantic County with the co-operation of Atlantic County Medical Society. All medical matters, physician's bills and disbursements were passed upon by an advisory committee of Society members. The cashier of a local bank acted as Trustee of the subscription fund.

### BASIC PROVISIONS

*Eligible Services*—General practitioner home and office care. Hospital care not included.

#### ANNUAL RATES

Single person	\$12.00
Family of two	16.00
Family of three	17.00
Family of four	18.00
Family of five	19.00
Family of six or more	20.00
Additional \$10.00 fee for obstetrical care	

#### PHYSICIAN'S FEE

Office calls	\$ 1.00
Home calls	2.00
Obstetrical delivery	25.00

### EXPERIENCE—1939

Number enrolled:	
Families	84
Total persons	320
Office calls per person per year	2.34
Home calls per person per year	.82
Sick rate per 1,000 per month	72.8
Cost of medical care per person per month	\$ 0.342

The fee schedule was maintained except during two months when pro-rating was 84 and 92 per cent. This deficit was made up later in the year. There was a small surplus of funds at end of year.

### EXPERIENCE—1940

Available reports are not complete. The experience justified a request by Farm Security Administration that the Plan be placed on a state-wide basis and that it be administered under control of the medical profession through Medical Service Administration.

### EXPERIENCE—1941

Medical Service Administration was organized by The Medical Society of New Jersey

as a medical service corporation under the provisions of a special Enabling Act, for the purpose of improving medical care distribution. Twenty-six hundred physicians are "Participating Physicians".

No changes were made in the original basic provisions of the Plan. Physician's fees \$1.00 in office and \$2.00 in home.

#### NUMBER ENROLLED

Families .....	416
Total persons .....	1916
Office calls per illness .....	1.26
House calls per illness .....	.69
Sick rate per 1,000 per month .....	60.5
Cost per month per person .....	\$0.20

#### EXPERIENCE—1942 (6 MONTHS)

##### PHYSICIAN'S FEES

Office calls .....	\$ 1.50
House calls .....	2.50
Obstetrics .....	35.00
(No change in subscription rate)	

##### ENROLLMENT

Families .....	406
Total persons .....	1837
Calls per illness .....	2.4
Ratio of calls	
Home .....	1
Office .....	2½
Sick rate per 1,000 per month .....	75
Cost per month per person .....	\$0.285

(The increase in sick rate (75) was mainly

due to prevalence of respiratory infections during month of March when rate was 120.)

#### COMMENTS

- I. Experience improves as size of enrolled group is increased.
- II. Office and home care at sick rate of 60.5 and fees of \$1.00 in office and \$2.00 in home were furnished at cost of twenty cents per month per person.
- III. Office and home care at sick rate of 75 and fees of \$1.50 and \$2.50 were furnished at cost of 28½ cents per person per month.
- IV. Anticipated sick rates may be used as a basis of estimating the costs of medical care of the indigent load in a community or a state.
- V. Clients of Farm Security Administration receive more and better medical care than before inauguration of the Plan.
- VI. The gross income of physicians from this group is increased by this Plan. The fee per individual case or service is in many instances less than might otherwise be obtained.
- VII. The Plan has the approval of each County Medical Society, the Board of Trustees and House of Delegates of The Medical Society of New Jersey.
- VIII. A continuation of the Farm Program was voted by the House of Delegates at its annual meeting in April, 1942.

## ANNUAL CONFERENCE OF SECRETARIES AND EDITORS

The 1942 Annual Conference of Secretaries and Editors of Constituent State Medical Associations was held in Chicago on November 20 and 21 at the A. M. A. Headquarters. The sessions began on Friday morning at 10 o'clock and the call to order was made by Dr. Roger I. Lee of Boston, Chairman of the Board of Trustees of the A. M. A.

Dr. Fred W. Rankin, President of the A. M. A., gave the opening address, which set the theme of the meeting—the participation of the medical profession in the various phases of the war effort. He emphasized the widespread and very effective response of the medical profession to date. Dr. Rankin pointed out that while the needs of the Armed Forces unquestionably held the position of priority regarding the medical profession's services, every effort would

be made to provide civilian defense medical services required to maintain the health of the civilian population and to protect them in case of injury and illness.

Dr. Ross T. McIntire, Surgeon General of the United States Navy, expressed a sincere appreciation of the response of the profession to the call of the Navy for medical personnel. He stated that not only had the response been quantitatively satisfactory, but the quality of the personnel and their fine attitude and willingness to learn how best to meet the needs of the Naval Forces, insured adequate and high quality service.

Dr. Frank Lahey, Chairman of the Board of Procurement and Assignment Services for Physicians, Dentists and Veterinarians, spoke enthusiastically of the medical profession's re-

sponse to the call of the Army. At the same time Dr. Lahey emphasized the fact that more physicians will be needed if the present estimates of increase in the Armed Forces are put into effect. Dr. Lahey spoke of the fine attitude on the part of the Manpower Commission under Mr. McNutt and the coöperative aid rendered on all occasions by the men in charge of the various branches of the Armed Forces. He stated that there is an increasing realization on the part of the profession that the various procedures required in the enrollment and use of medical men was essential in spite of mistakes honestly made and corrected as soon as better ways and means were developed.

The Surgeon General of the United States Army was represented by Brigadier General Charles C. Hillman. Surgeon General Magee, in accepting an invitation to speak to the Editors and Secretaries, did so with the proviso that he might send a substitute and his choice was most acceptable to those present. Brigadier General Hillman expressed for the Surgeon General the deep appreciation of the Army for the assistance so willingly given by those physicians who volunteered directly or through Procurement and Assignment were made available to the Medical Corps of the Army.

The outstanding feature of the morning session was the evidence of appreciation expressed by all representatives of the Armed Forces for the generous attitude of understanding and co-operation exhibited by the medical profession in their efforts to be of most service in the posts to which they were assigned. In spite of all criticism to which the physicians have been subjected in recent years, the governmental representatives were united in acknowledging their dependence upon the profession for the health care and restoration as well as the rehabilitation of those physically handicapped.

Luncheon was served by the A. M. A. hosts to all in attendance at the meeting and the afternoon was devoted to addresses. Dr. James E. Paullin, President-Elect of the A. M. A., opened the afternoon session.

He was followed by Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, who spoke on the health of our nation in wartime, stressing the civilian needs, especially those of the individual workers providing the materials of war.

Dr. Leonard G. Rowntree, Chief of the Medical Division of the Selective Service, spoke of the problems of this system in endeavoring to provide for the medical needs of the war. He stated that the coöperation re-

ceived from the various organizations within the government and the physicians themselves made bearable the many difficulties that had arisen and which continue to arise in fulfilling the duties of the Selective Service to provide qualified manpower.

Dr. Creighton Barker discussed the problem of providing physicians for civilians and for the Armed Forces through Procurement and Assignment as it was met at the state level by the Connecticut State Medical Society, of which he is Secretary.

Dr. Walter F. Donaldson, Chairman of the newly appointed War Participation Committee of the A. M. A., explained the work of this committee as anticipated at the time of its appointment last June, and showed the reasons for the termination of the Medical Preparedness Committee at its own suggestion, stating its belief that a new plan and scope of work would be needed from now on.

Following the morning and afternoon sessions there was opportunity for discussion, and insofar as the time permitted certain points were further discussed by those in attendance.

Dinner was served at 6:30 at the Palmer House, to which the A. M. A. hosts invited all in attendance at the conference as their guests. This session was primarily for the editors of state medical journals. Dr. Stanley B. Weld, Editor-in-Chief of the Connecticut State Medical Journal, presided. In his brief opening address Dr. Weld spoke of some of the problems of editors in state medical societies, and pointed out the problems faced in the preparation of his journal, which were similar to those faced by editors of other state medical journals.

Dr. Julian P. Price, Secretary and Editor of the Journal of the South Carolina Medical Association, gave a most interesting and constructive criticism of the composition of his own and other state journals, and centered his address largely on a plea for state journal editors and writers to keep in mind the average members among the general practitioners who look primarily to their state journal for guidance and instruction, both in professional procedure and in organized efforts in which the profession in their state is primarily concerned. Dr. Price cited as examples of merit the contents of certain journals, and The Journal of The Medical Society of New Jersey was one of the half dozen mentioned by name. Dr. Price emphasized readability, both as to the subject matter and its presentation, and stated that in certain forms of presentation a leaf could be taken from the style of "Time". His address was constructive, witty and brief, and



held the interest of his audience throughout. The subject was discussed by Dr. Morris Fishbein who made the point that the presentation of scientific material on the state and national levels often required two different treatments and criterion for acceptance of manuscripts.

The Saturday morning session at the A. M. A. headquarters was most valuable. Dr. John H. Fitzgibbon of Portland, Oregon, described a most interesting set-up to provide for the health needs of industrial workers in a larger area including Portland, and also a number of places where the available facilities were far from adequate. The Henry Kaiser shipyards are within this large area and a comprehensive survey of existing facilities and personnel was made in an amicable and effective coöperative effort to solve the problem. All agencies and individuals concerned in this health program were first surveyed and then enlisted and assigned specific responsibilities in the program.

Medical service plans, as organized and about to go into effect in Massachusetts, were discussed in detail by Dr. James C. McCann, President of the Massachusetts Medical Service. Here the distribution of the service through contracts and administration was left under proper safeguards by the medical societies in the hands of the Hospital Service Administration. It was felt that the doctor's scope of service begins when the patient and the doctor are brought in contact in time of need, and that the details of distribution of service and payment on the service plan are

most economically and efficiently carried out by groups trained in that particular field.

The medical service plans as operated in several states under the Farm Security Administration, in coöperation with Medical Service Plan organizations, was described in detail by Mr. A. M. Simons. The Farm Security Plan was originated and organized by the Federal Government and subsequently has been absorbed in certain places by the State Medical Service Administrations, as in New Jersey. The strong and weak points of such experimental plans were discussed by Mr. Simons and some of those in the audience. Dr. Norman M. Scott of New Jersey, in the discussion of medical service plans in general, gave the essential facts regarding the New Jersey experience to date.

Father Alphonse M. Schwitalla, Vice-President of Michigan Medical Service Plan, described this subject especially as it affected hospital services and the private hospital.

The entire conference was a valuable contribution to the program and the projects discussed. Those in attendance at these meetings had a rare opportunity to discuss their experiences frankly with each other, giving attention to the unsuccessful as well as the successful efforts, and helpfully suggest what they believe to be the causes of the less successful efforts. The arrangements were most satisfactory, the program very constructive and the meeting proved to be a good investment of time for all concerned.

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## UNITED STATES PUBLIC HEALTH SERVICE RESERVE COMMISSIONS

A joint meeting was held at the Executive Offices, 222 West State Street, Trenton, on Sunday, November 1, at 10:30 a.m. Dr. Sigurd Johnsen presided and those present were: Drs. Hawkes, Lewis, Carlisle, Zehnder and Wilkes.

Dr. Johnsen reported that he had a satisfactory interview with Drs. Baehr, Hyde and Schlichter of the Emergency Medical Service for Civil Defense, and that Dr. Baehr had stated that the purpose of his request to the U. S. P. H. S. that they grant commission to the men serving on the emergency staffs of the base hospital units, five in number in New Jersey, and which are to be associated with specified regular hospitals, was solely for the purpose of insuring an *organization* in which the *authority* was definitely vested for calling these staffs into being, in times of emergency caused by enemy action. The personnel to be commissioned for service with these hospital units is

selected by the New Jersey Emergency Medical Officer, Dr. Schlichter, and a staff of 75 men is to compose the five units. The selections submitted by the Emergency Medical Officer of New Jersey must in turn be *approved* by the National Emergency Medical Officer, Dr. Baehr, and Surgeon-General Parran of the U. S. P. H. S. The staff of each emergency hospital unit is to consist of eight surgeons, five internists, one radiologist and one pathologist. These men will be commissioned on the *inactive* service and will be paid only when called into active service in the emergency. Their ranks will range from Lieutenant-Colonel down. They are to serve with the base hospital units in their own region (but when a physician accepts a U. S. P. H. S. commission there are no qualifications attached to it in the final analysis, for they are subject to the same authority and direction as other commissioned officers. While it is the plan and

intent that such officers will serve only in disaster caused by enemy action and in their own locality, the following specific questions were put to the authorities and their answers are appended thereto:

1. Where does a member of the U. S. P. H. S. agree to serve?

*Answer.* (See last sentence in above paragraph.)

2. Is there more than one type of commission issued, i. e., is there any modification or qualifying commission issued?

*Answer.* There is but one type of commission—that of Reserve Officer in the U. S. P. H. S. Different ranks are provided.

3. Who is authorized to call men from inactive service to active duty?

*Answer.* This is done by the U. S. P. H. S. on recommendation of the State Emergency Medical Officer.

4. May a member on inactive duty refuse active duty?

*Answer.* No.

5. Can units be called to service outside their own state? If so, can they be sent anywhere in the United States?

*Answer.* No.

6. Must a unit be called en masse, or can one member of the unit be called separately?

*Answer.* The unit is called en masse only.

7. If the whole unit is called, can one member refuse to go on active duty or is he bound by the action of the unit?

*Answer.* All must go.

8. Can the Surgeon-General of the U. S. P. H. S. declare an emergency in a specific

locality and assign men to active duty in that location?

*Answer.* (See answer to question 3.)

9. Can men be assigned to the unit who are not members of the staff of the hospital from which the majority of men are recruited?

*Answer.* Yes.

10. Who decides when the period of emergency exists and is over?

*Answer.* The State Emergency Medical Officer.

11. Has the Surgeon-General of the U. S. P. H. S. officially declared that men accepting commission will only be assigned to active duty in hospitals?

*Answer.* Yes.

12. Can the Surgeon-General of the U. S. P. H. S. modify or change these requirements at his own discretion?

*Answer.* No.

The combined committee recommends as an outgrowth of their discussion on this subject that the county medical societies mobilize the available medical manpower in their respective counties to the end that there shall be no breakdown in medical service to the civilian population. It has been called to our attention that from certain communities already complaint has reached Washington to the effect that at night and over week-ends it has been impossible to obtain medical care. The committee believes that through proper organization and coördination of effort, it should be possible to assure adequate medical service to every community at all hours of the day and night.

### PRAISE FOR DR. SCHLICHTER

On October 12th, New Jersey reached 100 per cent of its 1942 quota of physicians for the armed forces. Since October 12th, no other physicians of New Jersey have been declared "available for military service" excepting for a few who were being processed at the time and a few others who, having made all preparations for active duty, found it most con-

November 24, 1942

Dr. Charles H. Schlichter  
556 North Broad Street  
Elizabeth, New Jersey

Dear Dr. Schlichter:

As you know, the cumulative totals for October 31st are now available and have come upon my desk. I note that New Jersey has now 107 per cent of its quota and I am writing to congratulate you, Dr. Scott and the medical profession in New Jersey for this accomplishment. This, as you know, is in ad-

venient to apply for a commission prior to the announcement of our 1943 quota. The following letter has been received from Dr. Frank H. Lahey, Chairman of the Central Procurement and Assignment Board, congratulating the medical profession of New Jersey on its accomplishment:

vance of the requirements of the Army because their requisitions are as of January 1st, 1943.

In addition, may I say for the Central Board of Procurement and Assignment that it appreciates the complete coöperation it has received from you and Dr. Scott and from the medical profession of New Jersey.

It has been a pleasure to work with two such coöperative representatives as you and Dr. Scott are, with such an obligation-conscious profession.

With most sincere regards,

FRANK H. LAHEY.

## SUPPLEMENTARY LIST OF MEMBERS NO. 8

TO THE OFFICIAL LIST, MARCH 15, 1942

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

### ACTIVE MEMBERS

Abramo, Anthony E., 141 Glen ave., Midland Park (2)  
Anderson, Ethelyn J. C., 59 Seely ave., Arlington (7)  
Ashby, Clifford, 59 Evergreen pl., East Orange (7)  
Bracy, Raymond J., 61 Kenmore ave., Newark (7)  
Brunkow, Charles D., 31 Lincoln Park, Newark (7)  
Burstein, Rachel, 72 Osborne ter., Newark (7)  
Chattin, J. Franklin, 671 Broad st., Newark (7)  
Christensen, Osborn D., 315 Terrace ave., Hasbrouck Heights (2)  
Cordasco, Peter, 24 Dodd St., Bloomfield (7)  
Duffy, Joseph F., 358 Kinderkamack rd., West'd (2)  
Dulany, Theodore L., 170 W. Market st., Newark (7)  
Fermaglich, Harry B., 881 Garrison ave., Teaneck (2)  
Fessler, William, 31 Knox ave., Grantwood (2)  
Fink, A. Elston, 459 High st., Newark (7)  
Flax, Jacob L., 31 Lincoln Park, Newark (7)  
Friedenberg, Sidney, 2990 Alabama rd., Camden (4)  
Friedlander, Kurt, 413 Lyons ave., Newark (7)  
Gadek, William V., 84 Harrison pl., Perth Amboy (12)  
Girardo, Anthony J., 22 Taunton ave., Berlin (4)  
Grimes, Jesse R., 214 Washington ave., Dumont (2)  
Horner-Rodger, Clara L., 937 Cooper st., Camden (4)  
Howell, E. Gaylord, 120 New st., New Brunswick (12)

Irving, H. Clay, 13 Warner ave., Jersey City (9)  
Loksa, Harold T., 520 Washington st., Boonton (14)  
Miele, Frank A., 314 Carr ave., Keansburg (13)  
Platt, Edward V., Med. Det., 149th Inf., Camp Shelby, Miss. (4)  
Sarajian, Aram M., 131 Ayers ct., W. Englewood (2)  
Schiffmann, Samuel, 107 Spruce st., Newark (7)  
Shapiro, Ralph N., 819 S. 12th st., Newark (7)  
Shapiro, Samuel, 209 Avon ave., Newark (7)  
Stetser, Leland M., 920 Haddon ave., Collingswood (4)  
Strauss, Wm. T., 6 Jerome pl., Upper Montclair (7)  
Tepper, Victor, 2 Parkview ter., Newark (7)  
Weiss, Mortimer H., 511 Clinton ave., Newark (7)

### ASSOCIATE MEMBERS

Belott, Louis V., 276 Springdale ave., E. Orange (7)  
Eisenstadt, Lester, 51 Grumman ave., Newark (7)  
Hansen, Harold T., 533 Mt. Prospect ave., Newark (7)  
Kempe, George, 974 Caldwell ave., Union (7)  
Kramer, Bernard M., 236 State st., Perth Amboy (12)  
Marin, Robert B., 284 Bellevue ave., Montclair (7)  
McNeely, Julia A., 117 Washington st., E. Orange (7)  
Ormsby, Thomas J., 1180 Raymond Blvd., Newark (7)

## MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY NOW SERVING ON ACTIVE DUTY IN THE ARMED FORCES

### SUPPLEMENTARY LIST NUMBER SEVEN

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Aitken, Frank J. T., Bridgeton (6)  
Anderson, Robert C., Newark (7)  
Anderson, William A., Newton (3)  
Assante, M. Hugo, Clementon (4)  
Austin, Thomas R., Cranford (20)  
Baime, Jules E., Newark (7)  
Baker, Maelyn F., Irvington (7)  
Balsamo, Joseph J., Newark (7)  
Barnett, Lester A., Milltown (12)  
Berkow, Samuel G., Perth Amboy (12)  
Bernhard, William G., Newark (7)  
Bernstein, Benedict J., Plainfield (20)  
Binder, Israel L., Newark (7)  
Bleiberg, Jacob, Irvington (7)  
Borow, Louis S., Bound Brook (18)  
Boyt, Theodore, South River (12)  
Brady, Raymond J., Newark (7)  
Brandman, Otto, Newark (7)  
Bruning, Richard H., Maplewood (7)  
Calasibetta, Charles J., Newark (7)  
Callahan, Edward J., Westfield (20)  
Cardwell, Edgar P., Newark (7)  
Casagrande, Stephen R., Belmar (13)  
Cetrulo, Gerald I., Newark (7)  
Chimacoff, Hyman, Irvington (7)  
Chmelnik, Abraham G., Newark (7)  
Chodosh, Maurice A., Carteret (20)  
Clement, Baxter L., Newark (7)  
Coffin, Henry F., Newark (7)  
Cohen, Sidney A., Newark (7)

Cohn, George M., Newark (7)  
DeGerome, James H., Glen Ridge (7)  
DeSantis, Orazio J., Millville (6)  
Devlin, Arthur D., Newark (7)  
Drössner, Jacob J., Camden (4)  
Dunn, H. Irving, Elizabeth (20)  
Dwoyer, Leon C., Linden (20)  
Erdman, George L., Newark (7)  
Eynon, Harold K., Collingswood (4)  
Eynon, James R., Collingswood (4)  
Fader, Ferdinand, East Orange (7)  
Fischman, Harold H., Newark (7)  
Flanagan, John J., Newark (7)  
Fluck, David A., Trenton (11)  
Forbes, John S., Jr., Basking Ridge (14)  
Forte, Daniel L., Orange (7)  
Forte, Frank S., Newark (7)  
Fortuin, Floyd, Paterson (16)  
Francy, Donald G., Lyndhurst (7)  
Freeman, George C., Newark (7)  
Friedenberg, Sidney, Camden (4)  
Gadek, William V., Perth Amboy (12)  
Galioto, Frank M., Bloomfield (7)  
Garfinkel, Abraham, Flemington (10)  
Germain, Raymond J., High Bridge (10)  
Girardo, Anthony J., Berlin (4)  
Glazier, Jesse T., Newark (7)  
Golden, Clement H., Newark (7)  
Greene, Edwin C., Bridgeton (6)  
Greenwood, William R., New Brunswick (12)



- Gullord, Edward G., Upper Montclair (7)  
 Hackett, Edward J., Westfield (20)  
 Hall, Wayne W., Paterson (16)  
 Halpern, Melvin M., Newark (7)  
 Hesselstine, Clair E., South Amboy (12)  
 Hicks, Alfred M., Montclair (7)  
 Horn, Harry, Irvington (7)  
 Hughes, Joseph F., Woodbury (8)  
 Johnston, Rufus O., Harrington Park (2)  
 Judge, John F., Newark (7)  
 Karshmer, Ernest E., Linden (20)  
 Karshmer, Nathan, New Brunswick (12)  
 Kennedy, William M., Verona (7)  
 Kimmel, Charles, Bloomfield (7)  
 Klein, Andrew J. V., East Orange (7)  
 Kohn, Joseph J., Trenton (11)  
 Kondor, Joseph S., Trenton (11)  
 Kramer, Bernard M., Perth Amboy (12)  
 Kunz, Harold G., Bloomfield (7)  
 Landry, Ernest J., Glen Gardner (1)  
 Levison, William, Newark (7)  
 Lewandowski, Edmund E., Irvington (7)  
 Licks, Frederick C., South Orange (7)  
 Lillien, Bernard B., Irvington (7)  
 Lipsitz, Leopold S., Camden (4)  
 Loksa, Harold T., Boonton (14)  
 Longo, James J., North Arlington (7)  
 Luippold, Eugene J., Jr., Boonton (14)  
 Lurie, Wolf, Bloomfield (7)  
 Lyerly, James M., Plainfield (20)  
 Maffongelli, Joseph A., Paterson (16)  
 Magolda, Anthony F., Vineland (6)  
 Marts, George H., Plainfield (20)  
 Mastroianni, Frank M., Union (20)  
 Matheke, Otto G., Jr., Newark (7)  
 McGlade, Thomas H., Camden (4)  
 McGuire, John J., Newark (7)  
 Miller, I. Irwin, Newark (7)  
 Miller, S. David, New Brunswick (12)  
 Mills, Stephen D., Westfield (20)  
 Mores, Herbert R., Ridgefield Park (2)  
 Moress, Edward J., Hillside (7)  
 Morris, Nathan, North Plainfield (18)  
 Moscoe, Harry A., Paterson (16)  
 Nadel, Charles I., Irvington (7)  
 Navazio, Attilio, Morristown (14)  
 Nieman, Solomon Z., New Brunswick (12)  
 O'Connor, Paul A., Newark (7)  
 Oshrin, Henry, West New York (9)  
 Parsonnet, Eugene V., Newark (7)  
 Paul, H. Carl, Caldwell (7)  
 Pentecost, Salvador D., Irvington (7)  
 Perham, Bertram S., Upper Montclair (7)  
 Platt, Edward V., Haddon Heights (4)  
 Pois, John, West Orange (7)  
 Polow, Benjamin, West Orange (7)  
 Pomeranz, Raphael, Newark (7)  
 Quad, Clifford W., West Orange (7)  
 Rachlin, Harry T., Newark (7)  
 Ravitz, Samuel F., Newark (7)  
 Reich, Henry, Newark (7)  
 Reilly, Christopher J., Newark (7)  
 Reinhardt, Warren I., East Orange (7)  
 Rodman, E. Warren, Beverly (3)  
 Rogers, Richard M., East Orange (7)  
 Rose, William G., Hightstown (11)  
 Rosen, Sol, Millville (6)  
 Rosenbaum, Samuel X., West Orange (7)  
 Rossi, Bartholomeo, Belleville (7)  
 Rubin, Benjamin, South River (12)  
 Russell, Karl S., Collingswood (4)  
 Russomanno, Raymond L., Newark (7)  
 Santoro, Thomas A., Newark (7)  
 Schmukler, Jacob, Maplewood (7)  
 Scielzo, Nicholas F., Paterson (16)  
 Shack, Maxwell H., Newark (7)  
 Shapiro, Ralph N., Newark (7)  
 Shapiro, Samuel, Newark (7)  
 Sheehan, Daniel C., Newark (7)  
 Shill, Benjamin, Newark (7)  
 Shlionsky, Herman, Cedar Grove (7)  
 Shulman, Murray W., Newark (7)  
 Simon, Henry, Newark (7)  
 Simon, Ludwig L., Newark (7)  
 Sinnott, Gerald W., Jersey City (9)  
 Smith, Wilbur A., Oaklyn (4)  
 Snagg, William T., Camden (4)  
 Somers, Willard H., Jr., Englewood (2)  
 Soschin, Samuel J., Newark (7)  
 Spritzer, Theodore D., Dunellen (12)  
 Spurgeon, Chilton E., Newton (19)  
 Staub, E. Milton, Westfield (20)  
 Steffens, Charles T., Dunellen (12)  
 Stetser, Leland M., Collingswood (4)  
 Stybel, Joseph, Plainfield (20)  
 Sufirin, Emanuel, Camden (4)  
 Tansey, W. Austin, Jr., Short Hills (7)  
 Tepper, Victor, Newark (7)  
 Tomec, Otto C., Trenton (11)  
 Torppy, John J., Newark (7)  
 Toy, Calvert R., New Brunswick (12)  
 Traganza, Robert W., Camden (4)  
 Tucker, Sidney, Perth Amboy (12)  
 Tushnet, Leonard, Irvington (7)  
 Vita, Frank J., Cliffside Park (2)  
 Warburton, Jack C., Paterson (16)  
 Weiss, Mortimer, Newark (7)  
 Wheeler, W. Kenneth, Newark (7)  
 Whinery, Joseph F., Summit (20)  
 Wolf, Raymond E., Glen Ridge (7)  
 Yorke, Edward T., Linden (20)  
 Zager, Saul, Newark (7)  
 Zimmerman, Coler, East Orange (7)

## MEDICAL CARE FOR CRIPPLED CHILDREN

In the Annual Report of the Elks Crippled Children's Committee of the New Jersey State Elks Association, April 1, 1941, to March 31, 1942, there is the following statement:

"Total expenditures for the past 14 years—\$1,840,645.37.

"In addition to this expenditure of money, services have been rendered by the orthopedic and plastic surgeons of the state, entirely with-

out cost. These services consisted of operative procedure, post-operative follow-up treatment, counsel and advice in the rehabilitation of crippled children. The cost of this service cannot be computed but would conceivably exceed that expended by the various lodges. We are deeply indebted to these surgeons for their very fine coöperation and wish to state they have made our task a much easier one."

## OBITUARIES

### DR. JOHN L. MACDOWALL

Dr. John L. MacDowall died in Perth Amboy on July 21, 1942, of coronary thrombosis. Dr. MacDowall was born on August 29, 1877, at Demorestville, Ontario, Canada. He graduated from Queens University in Kingston, Ontario, attaining his A.B. degree in 1900 and his M.D. in 1903. Upon graduation Dr. MacDowall took a post-graduate course in the Manhattan Eye and Ear Hospital of New York City during the next two years, and in 1905 began practice in Perth Amboy, where he became ophthalmologist to the City Hospital. He was for some years an assistant surgeon at the Manhattan Eye and Ear Hospital.

Dr. MacDowall was a member of the Middlesex County Medical Society, The Medical Society of New Jersey, and the A.M.A. He was a member of the Canadian Club of New York City, and a surgeon in the U. S. Naval Reserve (retired).

Dr. MacDowall's ancestors settled in the New England States late in the 17th and early 18th centuries. His great-grandfather was born in Balston, N. Y., and went to Canada in 1798 as the first Presbyterian minister in that part of the Dominion.

Dr. MacDowall's surviving relatives live in Canada.

### DR. BARCLAY W. MOFFAT

Dr. Barclay W. Moffat, aged 52, died suddenly at his home in Red Bank on October 28. Dr. Moffat graduated from Harvard Medical School in 1916 and was licensed to practice in New Jersey in 1920. He began to practice medicine in Red Bank immediately.

Dr. Moffat was a Licensiate of the American Board of Orthopedic Surgeons, Inc.; and a Fellow of the American Academy of Orthopedic Surgeons, American Orthopedic Association, American College of Surgeons and the Academy of Medicine of Northern New Jersey. He was a member of the Monmouth County Medical Society, The Medical Society of New Jersey and the American Medical Association.

Dr. Moffat was Attending Orthopedic Surgeon at the Fitkin Memorial Hospital in Neptune, Consult-

ing Orthopedic Surgeon of the Allenwood Tuberculosis Sanitarium and the New Jersey Crippled Children's Commission, and Associate Orthopedic Surgeon of the Post Graduate Hospital in New York City.

He took an active part in the conduct of the affairs of organized medicine in New Jersey and stood high professionally and personally with his colleagues in this state.

### DR. CLIFFORD R. NEARE

Dr. Clifford R. Neare, East Orange, died of a heart attack at his home on November 9, 1942. Born in Ohio 62 years ago, he attended the University of Cincinnati and was graduated from Cornell Medical School in 1896. He interned at Orange Memorial Hospital. He had been a consulting physician there since retiring from the active staff in 1938.

Dr. Neare was a member of the Essex County Medical Society, The Medical Society of New Jersey, the American Medical Association and the Orange Mountain Medical Society.

### DR. MAURICE L. RIPPS

Dr. Maurice L. Ripps, aged 43, died following an operation on October 28. Dr. Ripps was a native of Bayonne and attended the University of Michigan Medical School, where he graduated in 1923. He was licensed to practice in New Jersey in 1927.

Dr. Ripps was a pediatrician to the Elizabeth General, St. Elizabeth's and Alexian Brothers Hospitals in Elizabeth, St. Walburga's Orphanage in Roselle and the Seaview Tubercular Hospital in Staten Island.

He was a Fellow of the American College of Physicians and the American Academy of Pediatrics; a Licentiate of the American Board of Pediatrics; and a member of the Union County Medical Society, The Medical Society of New Jersey and the American Medical Association.

Dr. Ripps was a member of the Officers' Training School at Fort Sheridan, Ill., at the close of World War No. I, and was a member of the American Legion. He was active in the Elizabeth Y. M. H. A.

## DECEASED PHYSICIANS—NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
William F. Grady	61	Sept. 23, 1942	Orange	Montclair	Edema of lungs. Cardiac failure.
Frank A. Roberts	67	Oct. 17, 1942	Caldwell	Same	Acute coronary occlusion.
Morris L. Simon	52	Sept. 1, 1942	Passaic	Same	Carcinoma of liver.
Alfred W. Westney	68	Oct. 12, 1942	Northfield	Atlantic City	Acute coronary occlusion.

## ● THE BULLETIN BOARD ●

### MEETINGS

Dr. George P. Miley of Philadelphia will speak on "The Present Status of Ultra-Violet Blood Irradiation Therapy" at the meeting of the Gloucester County Medical Society, to be held at 9:00 p. m. on *December 17* at the Country Club in Woodbury.

### MEETING CANCELLED

The Board of Regents of the American College of Physicians has announced the cancellation of their 1943 Annual Session, which was scheduled to be held in Philadelphia, April 13-16, 1943. This action was taken after thoughtful consideration of all factors involved, including an intimation from the Secretary of War and the Office of Transportation that larger national medical groups should not plan meetings at the time set; a growing difficulty in getting speakers and clinicians of top rank to maintain the usual standards of the program; prospect of greatly reduced attendance, because civilian doctors are faced with too great a burden of teaching and practice already; a decreasing active membership, due to approximately 25 per cent of all doctors being called to active military service. President James E. Paullin announced, however, that all other activities of the College would be pursued with even greater zeal, and that the College would especially promote regional meetings over the country and organize post-graduate seminars in the various military hospitals for doctors in the Armed Forces.

### REFRESHER COURSES

Physicians interested in refresher courses in the various types of medical practice and the specialties can obtain a reprint recently issued by the Council on Medical Education and Hospitals of the American Medical Association, taken from the *Journal of the American Medical Association* of October 17, 1942, Vol. 120, pages 554-560. This reprint of eight pages embraces the continuation courses throughout the United States which are given under recognized auspices. The reprint lists the various subjects covered, the institutions at which they are given, the scheduled time of the courses, the titles of the courses, the number of students accepted and the registration fee and/or tuition.

### UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed \$500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, May 31-June 3, 1943, Hotel Jefferson, St. Louis, Missouri.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 1, 1943.

### NEW ENGLAND MEDICAL SERVICE

The July issue of the *New England Journal of Medicine* announces "Doctors Launch Medical Service". The Massachusetts Medical Society sponsored the newly formed mass medical service and joined the non-profit plan for hospital care to set in motion a non-profit service organized to meet a growing social problem. The enrollment of doctors began on August 4 and public announcement was to be made shortly after Labor Day by the president of the medical service organization, Dr. James C. McCann, and the hospital service president, Mr. George Putnam. It will be administered by the Blue Cross Hospital Service Agency, but operate as a completely independent corporation, having the same Executive Director, R. F. Cahalane, who has successfully administered the Hospital Service Plan. Its aim is to provide service for the low income groups, and subscribers' rates have as yet not been announced. Individual incomes of \$2,000 or less and family incomes of \$2,500 or less are to be completely provided. For those whose incomes are above this level the Plan operates with an established fee schedule.



## COUNTY SOCIETY REPORTS

### BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held at the Burlington County Hospital in Mt. Holly on November 12, 1942.

The Secretary read a letter from the Board of Trustees of The Medical Society of New Jersey relative to U. S. P. H. S. Reserve Commissions. The Board of Trustees approved the above program of U. S. P. H. S.

The discussion which followed the reading of this letter was not favorable to the proposed program.

DR. FAHRENBRUCH read a letter from the Maternal and Child Welfare Department of the New Jersey State Board of Health, in which there was a schedule of fees which this department would pay for the pre-natal, delivery of baby and also child care in cases of indigent enlisted and noncommissioned personnel of the Armed Forces.

DR. RALPH K. HOLLINSHED, President-Elect of the State Society, was the emissary of President Elias J. Marsh. Dr. Hollinshed pointed out the aims of the State Society. There will be no new projects; only the carrying through of those already started. Dr. Marsh would like the scientific side of medicine stressed more at this time. The State Society will facilitate the publishing of all such reports and will encourage scientific research. It was suggested that members of local societies present more medical topics at their meetings, rather than relying on outside speakers. Finally, State Society dues may be higher, due to the fact that so many physicians are in the Armed Service and are not paying dues.

DR. GEORGE T. TRACY was elected Secretary to fill the vacancy left by DR. E. WARREN RODMAN of Beverly, who is now in the Army Medical Corps.

At the succeeding meetings held at the Burlington County Hospital interesting cases which are in the hospital will be presented, one case to a meeting.

The December meeting of the County Society will be the annual meeting, and will be held in Moorestown, N. J.

### CUMBERLAND COUNTY

H. S. Branin, M.D., Reporter

The regular Fall meeting of the *Cumberland County Medical Society* was held October 13, 1942, at the Administration Building, Vineland State School, Vineland, N. J.

After the routine business of the Society was transacted, DR. RALPH K. HOLLINSHED, President-Elect of The Medical Society of New Jersey, was presented to the Society. Dr. Hollinshed gave a very brief but interesting talk on the plans and purposes of the State Society for the ensuing year.

DR. MILLARD F. SEVALL of Bridgeton, Chief of Medical Defense of Cumberland County, also gave a very interesting report of the Medical Defense situation.

DR. NORMAN M. SCOTT of the State Society was present and discussed several questions which concerned the Procurement and Assignment Service.

The office of Reporter was declared vacant and DR. H. S. BRANIN was named.

A program was presented in the form of a "Clinic of Mental Case Types" by DR. MARGARET E. SHIRLOCK and DR. SONIA CHEIFETZ of the State School. This clinic proved to be very interesting and instructive.

Following the presentation of the program, the Society gave Mr. Thorn, our host, a vote of thanks for his entertainment.

### GLOUCESTER COUNTY

On October 15 the *Gloucester County Medical Society* held its annual Social Evening at the Woodbury Country Club, and the efficient committee presented a program which was greatly enjoyed by the members and their guests. The invited guests included Dr. and Mrs. Elias J. Marsh, Dr. and Mrs. LeRoy A. Wilkes, Dr. and Mrs. William E. Dodd of Ocean County, Drs. Lancelot Ely and Frank L. Field of Somerset County, Assemblyman and Mrs. John G. Sholl, Mr. and Mrs. Harold W. Hannold and S. D. Distelhorst, First Lieutenant in the Signal Corps, and his wife.

DR. SHEETS, the President, presided, and very brief responses were made by the President of The Medical Society, the Executive Officer, and some of the other guests at the request of Dr. Sheets.

The entertainer, Roy Howells, was amusing and held the interest of the members and the guests throughout his presentation. The meeting was followed by a buffet supper and the whole evening passed quickly and successfully to the evident appreciation of all in attendance.

### HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Wednesday, November 4, 1942, at the Masonic Club, Jersey City, with the President, DR. T. MCG. BRENNOCK, presiding.

The following were elected to membership: DR. F. RICHARD DE VINCENZO and DR. RUDOLPH JACK KELLER of Hoboken, DR. CHARLES LOUIS QUAGLIERI and DR. LOUIS SOLOMON of Jersey City.

DR. Brennock introduced DR. JOHN J. MOORHEAD, Surgeon, New York Post-Graduate Hospital, and Colonel, Medical Corps, U. S. Army (In-ac), who spoke on "Treatment of Casualties in the Pearl Harbor Attack", which was illustrated by lantern slides.

DR. Moorhead furnished one of the most interesting evenings which the Hudson County Medical Society has had the pleasure of enjoying. He presented first-hand information concerning his experiences at Pearl Harbor on and after the Japanese attack on December 7th.

Dr. Moorhead stated that he had been invited by the Honolulu County Medical Society to give a post-graduate course in Hawaii and arrived there December 3rd, 1941. His first lecture was delivered on Thursday afternoon to a group of Army and Navy surgeons, principally. It was rather significant that the Friday night lecture was on "The Treatment of Wounds—Civil and Military". On Sunday morning the doctor lectured, during which time there was unusual military and naval activity. It was thought to be practice. The subject for the Sunday morning lecture was significantly "The Treatment of Burns". He was lecturing Sunday morning when the call came in that doctors were needed immediately. Dr. Moorhead was still an officer of the Reserve Corps, and when he arrived at the Tripler General Hospital he said that he never saw men so badly wounded in such a short period of time. He was called into active service with the rank of Colonel, and stayed in Hawaii for two months.

Dr. Moorhead's remarks were illustrated by lantern slides which showed the type of hospitals in Hawaii. The doctor stressed the necessity of debridement and stated that all diseased and dying tissue must be excised and the wound was not to be sutured tightly at the beginning. The sutures were not closed until the end of the third day. The necessity in the cases of gas gangrene was for early recognition. The treatment was sulfanilamide locally and also by mouth, giving fifteen grains every four hours for three days. Sulfathiazole, which was originally used, covered over the wound with a crust and held the secretion in. Numerous illustrations of the various types of wounds were shown. They were mainly in the buttocks and thigh due to the fact that the soldiers were taught to throw themselves face down when the missile came at them. The procedure in the treatment of these wounds was summed up as follows: Cleanse with soap and water; debridement, sulfa drugs; treatment of shock and transfusion when necessary. Fractures were nearly all compounded. Plaster casts were not used but instead traction was applied until after the third day, then a cast. All cases received tetanus antitoxin and sometimes tetanus toxoid. Closed cavity was made of chest wounds. Abdominal wounds were the most severe and most fatal. The application of x-ray in therapeutic doses was also advised in gas gangrene cases. An interesting observation was the fact that blood, from all the various races in the territory, was pooled and used with great success. Pentathol and evipal were of great aid in anesthesia. In conclusion, Dr. Moorhead praised, to the highest extent, the morale and stamina of the soldiers, sailors, nurses and the civilian population.

Dr. Moorhead then introduced MR. SAMUEL BERMAN, an electrical engineer, who demonstrated an apparatus called the "Locator" to determine the position and depth of foreign bodies. This machine was constructed by Mr. Berman under the guidance of Dr. Moorhead, and its efficiency was clearly shown in various tests made by the inventor. Those of us who have tried to remove a foreign body under the fluoroscope well realize the difficulties, and an apparatus of this type is of inestimable value. A

probe attached to the instrument is passed over the area of the body where the foreign body is thought to be and as it approaches the metal, a needle on the disc on the instrument accurately records the proximity of the probe to the metal. There was a discussion by DRs. SPRAGUE, LONDRIGAN, BARBARITO, ALTER.

Dr. Moorhead asked that a resolution be sent to the Honolulu Medical Society commending their valor and courageousness in the treatment of the wounded at the time of the Pearl Harbor attack.

It was moved and seconded that a committee of three be appointed to draw up this resolution.

The following is a copy of the communication sent by the committee of the Hudson County Medical Society to the Honolulu County District Society:

Dr. A. W. Buryea, Secretary  
Honolulu County District Society of the  
Hawaii Territorial Medical Association  
Honolulu, T. H.

Dear Dr. Duryea:

At a regular meeting of the Hudson County Medical Society held November 4th, 1942, Dr. John J. Moorhead of New York City gave us a very vivid account of the rescue and salvage work done at the Tripler General Hospital following the enemy attack on December 7, 1941, and the participation therein of the civilian physicians of Honolulu and its vicinity.

We wish you to know the deep impression which the unselfish participation of the members of your Society in the terrible aftermath of the Japanese assault made on the members of this organization who listened to his talk.

Please believe that we most sincerely appreciate the fine record of service of your members, and desire in this way to express to you our admiration and thanks for the way in which you exemplified the highest ideals of professional devotion.

Fraternally yours,

S. A. COSGROVE, M. D.

JOSEPH F. LONDRIGAN, M.D.

VINCENT P. BUTLER, M.D.

Committee.

## MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The Annual Banquet of the *Mercer County Component Medical Society*, held November 12th, was indeed a rousing success, being enjoyably augmented by a most befitting testimonial in honor of DR. HARRY R. NORTH, Treasurer of the Society.

Several State Officers were present, in addition to a large attendance of members in the Service.

PRESIDENT BLAUGRUND paid high tribute to the long-standing efficiency of the Treasurer as he presented DR. SCAMMELL as Toastmaster.

Dr. Scammell called upon several of the invited guests who expressed commendation in the highest terms of the sincerity of purpose, loyal support and untiring efficiency as outstanding characteristics of the many attributes of Treasurer North.

The esteem possessed by all members of the Society for Dr. North, as Treasurer and as a man, was materially demonstrated in an especially pre-



pared pencil portrait, with signatures of all members present at this auspicious occasion.

President Blaugrund presented the testimonial, and Dr. North, in accepting this token of esteem, expressed sincere gratification in the profound confidence thus reposed in his custodianship, and recited several interesting as well as ludicrous episodes during his early incumbency.

Music and good food enhanced the enjoyment of a delightful occasion.

The next meeting will be held December 9 at which time the annual election of officers will be held.

### MIDDLESEX COUNTY

A. M. Carr, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday, October 21, 1942, at Roosevelt Hospital, Metuchen, N. J. The meeting was called to order at 9:30 p.m. by the President, Dr. M. F. URBANSKI. The minutes of the June meeting were read and approved.

Upon recommendation of the Ethics Committee, the following were voted in as regular members: Dr. WILLIAM L. SALAKY, Perth Amboy; Dr. STANLEY GOBLE, Middlesex Boro; Dr. THOMAS F. McLAUGHLIN, Metuchen; and Dr. N. M. GOROG (now with U. S. Armed Forces), New Brunswick.

Dr. E. GAYLORD HOWELL of New Brunswick was reinstated as a full member.

Dr. WILLIAM H. McCORMICK of Perth Amboy and Dr. A. M. CARR of Metuchen were appointed as Treasurer and Reporter, respectively, to fill the vacancies of Dr. GEORGE J. KOHUT and Dr. CYRIL I. HUTNER, who are now with the Armed Forces of the country.

The 1942 Nominating Committee was appointed as follows: Dr. J. F. WEBER, South Amboy, Chairman; Dr. H. HAYWOOD and Dr. EDWARD F. KLEIN.

A resolution to revise Section Seven of the By-Laws was moved and carried:

**Resolution:** Resolved that the By-Laws Committee is hereby authorized and instructed to revise the existing By-Laws that will serve the best interests of the Society as a whole; and that a copy of the revised By-Laws be sent to all the members in good standing in ample time before the next regular meeting in November before any action for adoption is taken.

A motion by Dr. Kler was moved and carried that the President of the Middlesex County Medical Society appoint a committee composed of men above the draft age to be the Advisory Committee to the State Procurement and Assignment Service.

This committee to be appointed and to function on a municipal basis. The committee will draw up the list of physicians in order of their availability and the available men to be notified by the County Society. All appeals to be passed on by the entire Advisory Committee acting as a whole.

Dr. ELIAS J. MARSH, President of the Medical Society, gave a short talk on "Thoughts on Government Influence in the Future of Medicine".

Dr. CHARLES H. SCHLICHTER, State Representative of Office of Procurement and Assignment Service,

spoke on the subject of a physician's war-time obligation to his government. He said: "The service to our country during this war is not only a duty but a privilege." He told how the solemn obligation laid on the medical profession was being met in a very favorable way—with the State of New Jersey filling its quota.

He said the County Medical Societies were being asked to appoint committees to survey their membership and furnish Procurement and Assignment Service with a list of the men who are available and at the same time to make a list of the men who are absolutely essential in their hospitals and in their communities.

He told his audience that the Procurement and Assignment Service stands ready at any time to discuss with an individual or with the County Society any question which may be on his mind relative to entry into the service of the Army or Navy.

### MONMOUTH COUNTY

K. F. Metzger, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held October 28 at the Borden Memorial Pavilion, Monmouth Memorial Hospital, in Long Branch. Dr. HAROLD KAZMANN presided.

Dr. JEROME KAUFFMAN, instructor at New York Medical College, was speaker for the evening and discussed the treatment of congestive heart failure.

It was agreed that the expense for an expectant mother, suffering from poliomyelitis and receiving the Kenny treatment, would be shared in part by the county society, the cost being for nursing care.

The meeting was attended by several medical officers of the British Navy stationed in this country.

### PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held on November 17, 1942, at 9 p.m. at the Freeholders' Meeting Room in the County Administration Building in Paterson.

The meeting was called to order by the President, Dr. THOMAS A. CLAY, and the speaker of the evening was Dr. MAURICE BRUGER, Associate Professor of Medicine and Chief of Division of Pathological Chemistry at New York Post-Graduate Hospital. His topic was "Recent Advances in the Clinical Interpretation of Chemical Data". Dr. Brugger gave a clear, concise lecture on some of the newer laboratory procedures and their clinical significance. There were many questions.

No business session was held and the meeting adjourned early.

### UNION COUNTY

Fred B. Western, M.D., Acting Reporter

The regular meeting of the *Union County Medical Society* was held on Wednesday evening, November 11, at the Elizabeth General Hospital, with President GEORGE E. SEYMOUR presiding.

The minutes of the preceding business meeting, as well as those of the special meeting held following the death of Dr. MAURICE RIPPS, were read. Due



to the fact that almost a third of the members are now in the service, increasing the demands on the time of those remaining, there were not enough members present at this meeting to transact business. To avoid this situation arising again, it was suggested that for the duration of the war a quorum to transact ordinary business consist of 25 members; and that the presence of 40 members be sufficient for the election of officers and to take up revision of the constitution and by-laws. This matter will be considered by the Executive Committee and their recommendation will be acted on at the January, 1943, meeting.

The members present then enjoyed a talk by MAJOR SAMUEL C. YACHNIN, M.C., Chief of the Orthopedic Section, Station Hospital, Fort Dix, N. J., on "Treatment of Fractures and Other Traumatic Injuries in Military Service".

The speaker first considered *wounds*, stating that there were four essential steps in their care—wound toilet, chemotherapy, immobilization, and debridement—especially of the facia and muscle which are usually torn extensively; however, the skin should be conserved insofar as possible. In speaking of *fractures*, Major Yachnin pointed out that compound fractures occurring in combat differ from those encountered in civilian practice. The former, which result from foreign bodies such as bullets and pieces of shrapnel entering the tissues, compound the fracture from outside in, while the latter are compounded from the inside out. Chemotherapy and early immobilization in a cast were advised. *Amputations*, which are not done early, are often of the guillotine type; British surgeons in Libya have obtained excellent results by making two flaps, each consisting of skin and muscle, sewed together, leaving the wound open. The usual *anesthetic* is the open-drop ether method or, for short operations, intravenous sodium-pentothal. The treatment of *shock* was also stressed; administration of morphine and blood plasma are the most important

measures. Following Major Yachnin's talk, the meeting was adjourned, as there were not sufficient members present to transact business.

### WARREN COUNTY

Philip B. Kassow, M.D., Reporter

The regular annual meeting of the *Warren County Medical Society* was held at The Belvidere Hotel, Belvidere, N. J., on October 20, 1942.

There were eleven members present. The annual election of officers was held. The following were elected:

President, DR. GUERNSEY WEST

Vice-President, DR. HERMAN BALDAUF

Secretary, DR. RALPH BUCHANAN

Treasurer, DR. ARTHUR ZUCK

Delegate for 3 years, DR. PAUL DRAKE; Alternate, DR. FLOYD SHIMER

Delegate for 2 years, DR. W. H. VARNEY; Alternate, DR. GUERNSEY WEST

Delegate for 1 year, DR. H. B. BOSSARD; Alternate, DR. PHILIP B. KASSOW

Nominating Committee—DR. R. BUCHANAN; Alternate, DR. PAUL DRAKE

Censor, DR. SEYMOUR KIMMEL

Executive Committee are officers plus DR. W. H. VARNEY, DR. PAUL DRAKE

DR. SAMUEL ALEXANDER of Park Ridge, N. J., Second Vice-President of the State Medical Society, spoke briefly about the work and the difficulties the State Society has due to the present national emergency. He stated that the source of income has diminished, also that the state has refunded the dues to members entering the Armed Services. He asked that we be patient with the work of the Assignment and Procurement Division, since it is tremendous. He also stated that New Jersey should be proud of its record number of enlistees in the Armed Services.

The meeting was followed by the Annual Dinner with the Woman's Auxiliary to Warren County.

## NEW JERSEY CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

IRVING WILLNER, M.D., Secretary

The Fall Meeting of the New Jersey Chapter of the American College of Chest Physicians took place on September 25, 1942, at Bergen Pines, Bergen County Hospital, Ridgewood, N. J. Dr. Joseph R. Morrow, President of the New Jersey Chapter and also director and superintendent of Bergen Pines, presided. The meeting was attended by many members of the College and by a large number of guests from hospitals in the vicinity and by the staff of Bergen Pines. Dr. George M. Levitas of the Board of Managers of Bergen Pines and Dr. Samuel Alexander of the Board of Directors of Bergen Pines delivered addresses of welcome at the luncheon which preceded the meeting. The guest of honor was Dr. Winthrop Peabody of Washington, D. C., President of the American College of Chest Physicians, who spoke on the "Aims of the Amer-

ican College of Chest Physicians". He emphasized the organization of the college, the recent constitution that was adopted this year, and the importance of an institution devoted to the specialty of diseases of the chest, and for research in pulmonary diseases. The rigid requirements for membership, the work of the Council on Undergraduate Medical Education, the instructions given to general practitioners, and future plans of the national and international chapters of the college were discussed. An "X-ray Symposium" followed, during which many radiographs of interesting and unusual cases of pulmonary disease were presented and debated. The following members of the New Jersey Chapter have entered the Armed Services: Drs. Irving Applebaum, Paul K. Bornstein, William M. Kennedy and Meyer T. Weissman.

**PROGRAM**  
**1942 — 1943**  
**THE WOMAN'S AUXILIARY**  
**TO**  
**THE MEDICAL SOCIETY OF NEW JERSEY**

**PRESIDENT'S MESSAGE**

We open our Auxiliary activities for the current year in one of the most critical times in our country's history. There will be many changes in our own lives and in our Auxiliary work. However, as I greet you, let me say that no matter what task we may be requested to do, we will endeavor to perform it to the best of our ability.

The Medical Society of New Jersey has limited much of its activities and expenditures to the war effort. The Auxiliary, in turn, should follow the same policy.

Some of our committee chairmanships have been combined—History and Archives. Arts and Hobbies will be suspended for the year, since there will be no convention and no exhibit. Medical History can and should be continued. With over 1400 New Jersey physicians in the services, medical history is being made perhaps more rapidly than we are aware.

There is a real need for many of our activities—Public Health, Public Relations, Medical Legislation and Nursing Scholarships. Auxiliary members should keep informed on Medical Legislation and endeavor to promote that which is favorable and discourage that which is detrimental to the public health and the profession. Members should avail themselves of the opportunities afforded by courses of First Aid, Nutrition, Home Nursing and Nurses' Aide.

We, as physicians' wives, are expected to be leaders. We can only be such leaders by keeping informed on all matters pertaining to public health and medicine.

Do not allow your County Auxiliary to lose its identity—publicize your good work.

Many members will be away from their homes—keep in touch with them.

Invite visiting physicians' wives to attend your meetings—they will appreciate it, and you can gain much by these contacts.

My best wishes to you all for a successful and harmonious year.

Mrs. J. Howard Hornberger  
Brookside  
Roebling

LEAH M. HORNBERGER,  
*President.*

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**MESSAGE FROM THE PRESIDENT OF THE MEDICAL SOCIETY  
OF NEW JERSEY**

It would be no news to tell you that the medical profession of the State faces a difficult and trying time. The uncertainty of what may happen next to those men already in the services and to those who may be called next are the problems facing those who will remain at home. The facilities we will have for meeting those problems and the effect they will have on your own personal lives and fortunes are familiar to you all. Each member of the Auxiliary has her own personal problem. Yet you wish to know how your organization can help to solve the general problem and carry out the program of the Medical Society. This is no more than we, who have faith in you individually and know the record of your organization, would expect; but it is nonetheless a source of pride to your husbands, sons and brothers in the Society.

I hardly know what to say to you. The Society's program for the coming year, and for the duration of the present emergency, is to subordinate all activities not essential to its vital functions, that are not chiefly contributory to the national war effort, and to concentrate all our forces on those that are. These, of course, will be chiefly directed to the immediate protection of the health of the civilian population, and especially to those concerned in the war work, with their families, whether through public health measures, communal organizations, or private practice. But the conditions under which we must work, and the problems of patient-load, supply, and communication are so new and strange. Moreover, they change so frequently that any concise or defined program is impracticable, except from month to month or less. The various officers and committees of the Society are constantly

striving to anticipate the problems that may arise, and to meet the changes as they come. In some of these your aid will be helpful and welcome. I can only suggest that you keep yourselves informed and be prepared to take advantage of the opportunities offered. There is little more that any of us can do now.

One thing that I may add will be of interest to you. Most of the resort hotels in the State have been taken over by the Army or the Navy for the use of their forces, as you know; and probably by next spring all of them will be. This, together with lack of transportation and pressure of other business, will force the omission of the customary social features as well as the exhibits at our Annual Meeting in 1943. Present plans provide for a one-day, or day and a half, business meeting only; the attendance is not expected to be very large. This will undoubtedly affect your annual meeting arrangements and I am presenting the information now so that you will have time to make your plans accordingly.

We are grateful for your assistance rendered so freely in the past, and appreciate your generous offer of further effort for the Society in these troubled times.

ELIAS J. MARSH, M.D., *President*,  
The Medical Society of New Jersey.

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### PARLIAMENTARY PROCEDURE IN MEETINGS

Any club meeting, whether large or small, should be conducted in an efficient and orderly manner. The average club woman may feel that parliamentary procedure is much too formidable, nevertheless, it is only necessary to become acquainted with the basic fundamental rules in order to easily participate in any meeting.

"Robert's Rules of Order, Revised" contain the parliamentary rules of procedure which are used by the National and State Auxiliaries. County Parliamentarians will find it helpful to follow these with small study groups.

Please feel free to call upon your Parliamentarian for assistance at any time.

Mrs. Joseph J. Ruvane  
38 Bentley Avenue  
Jersey City

ANNE S. RUVANE,  
Parliamentarian.

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### PROGRAM

The slogan set down by our National President, Mrs. Frank Haggard, "Working Together Is Success", seems to this writer to be a thought worthy of consideration. A practical application of this slogan would be to plan a well-rounded program for your Auxiliary.

Many avenues of activity are open for you and it is not the idea of your program chairman to lay down any hard and fast rules. It is wise for each county program chairman to consider the many suggestions which follow and to select the activities most suitable to your particular group.

Auxiliary members are no exception to the women throughout the country who are lending time, thought and effort in helping win the war.

Because of this situation many suggestions will bear on the war.

Following is a list of suggestions. Before setting them down I wish to emphasize certain ideas which pertain particularly to New Jersey.

New Jersey has an enormous number of defense workers within its borders. As a result, hospital facilities are taxed to their utmost. Because of this it is advisable for the different county units to endeavor to have their members join up for a course in Nurse's Aides, Home Nursing, Canteen and Nutrition Courses.

These courses will be of inestimable value to the people in your community but also to the women who avail themselves of these courses. Your local Red Cross Chapter will welcome you to any of these classes or your Auxiliary may act as a sponsor for any of these courses.

Following are many suggestions for a program. Select the items which are best suited to the needs of your Auxiliary.

1. a. Special Study of Local Health Problems, particularly those made acute by military and defense plants.
- b. Study of health and defense work.



2. To appoint a Nutrition Council in each Auxiliary, for study of standard course in nutrition or advance course in canteen workers.
3. All Auxiliary members are especially urged to take a course in Home Nursing or use these lessons in place of a program.
4. a. New changes in medical government.  
b. New medical legislation.  
c. How women can help to control inflation.
5. a. Study about how medicine is practiced by our good neighbors in South America and Canada.  
b. Defects of war in the English people.
6. a. Study about how the American doctor is helping to win the war.  
b. New War Medicine—New medical methods which have been developed during this war.
7. Stress more quiz programs this year. Send to National Chairman for a copy of "Be Informed" and base other quiz programs on this, using your County and State Auxiliary, State History, Hygeia, and the new Auxiliary Hand Book as a source of material for these quiz programs.
8. Panel discussions, with County or State officials as guest leaders.
9. In place of regular programs, give instructions in public speaking, so that the Auxiliary members may become well informed and interesting speakers on topics of health and medical economics.
10. Every Auxiliary should review the survey of women's health interest which has been compiled by the Bureau of Health Education of the American Medical Association.
11. The timely book review always makes an interesting program, particularly those on medical subjects.
12. Morale and mental hygiene.
13. What is a physical health examination? And how the American public, and especially the doctors' wives may keep fit by having a yearly check-up.
14. Don't fail to include social gatherings in your program.
15. Consult Hygeia and American Medical Association Journal for interesting program material.
16. Current medical events are very essential in this rapidly changing world.
17. How the various services have been organized by the National Physicians Committee of Extension of Medical Service.
18. This year our National President is Mrs. Frank N. Haggard, of San Antonio, Texas; and if possible, arrange a date with her. She will be a source of great inspiration to your Auxiliary.
19. A special program, Doctors' Day—Have a program on pioneer doctors of your community.

Mrs. R. J. McDonald  
80 Park Avenue  
Paterson

ISABEL McDONALD,  
Chairman.

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## ORGANIZATION

We are probably as well organized now as we shall be for the duration. It is doubtful if there will be any new counties to be mothered during this wartime period. The existing county groups must be held together, encouraged in their community and national efforts, and aided in effecting the ultimate good for all after this conflict is over. Let us maintain the friendship between families and individuals, one of the causes for which our men are fighting.

The National Chairman of Organization has suggested the discontinuance of dues of the wives of doctors in the service for the duration. This procedure is used in Colorado and where practical can be adopted by any Auxiliary.

Your Chairman will appreciate receiving any alternate suggestions you may have to offer.

Mrs. Emanuel M. Sickel  
318 Forest Avenue  
Lakewood

BESS SICKEL,  
Chairman.

## PUBLIC RELATIONS

Much has been written on the functions of a Public Relations Committee, and yet, it does not seem unwise to repeat some of these ideas, and in addition to offer a few new thoughts.

What better service can a Public Relations Committee render than to promote authentic health information concerning prevention of disease, nutrition and all other matters of health?

1. Auxiliary members should assume leadership in the field of nutrition as public interest is demanding dietary knowledge free from fads and fancies; hence here we have a rare opportunity to serve. With the possibility of the rationing of many foods, on which our armed forces must have first claim, this knowledge will be of greater value than before.

2. It is still our duty to acquaint the public with the means of authentic information on health. Our country needs every man, woman and child in our all-out effort for Victory.

a. To accomplish this, organize *health committees* in lay organizations.

b. All of us must know how large a percentage of our manhood, upon examination has been deemed unfit for service. This fact indicates a lack of physical education and proper nutritional information.

3. Practical assistance to families of physicians in Army Centers is another project which should be uppermost in the minds of Auxiliary members, and is one which can be developed very successfully in the counties nearest the large camps.

4. It is our further duty to present the attitude of The Medical Society on specific health issues.

5. Wherever possible, supply and schedule speakers for lay groups on the subject of "American Medicine, Past, Present and Future"; also on "Pan-American Unity".

6. Coöperation in all forms of National Defense is not only desirable, but is essential. This includes Nurses' Aides, Red Cross, First Aid, Blood Donors, Mobile Units, Air Raid Precaution and others. All these are our Home Front.

7. Clip any editorial or letter which is detrimental to the doctors, medical societies or hospitals. The Medical Society wants to answer these criticisms. All Auxiliary members should coöperate in this.

8. Publicize the A. M. A. broadcasts—"Doctors at War".

If you have any ideas or suggestions, please submit them to your State Chairman. The foregoing is intended as a guide from which you can formulate your own program as best suited to your locality.

Never before has the doctor's wife had such an outstanding opportunity for leadership—let's make the most of it.

Mrs. Don A. Epler  
45 Hillside Avenue  
Newark

BETTY EPLER,  
Chairman.

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## MEDICAL HISTORY

Although our days are full with war activities, County Committees should make an even greater attempt to bring their medical histories up to date. These should be completed and filed in the Archives of the State Medical Society before the records of this war are compiled.

This project is well worth while and should be carried on as a part of our war effort. As we honor the dead and those who have given service in the past, we will better prepare ourselves to honor those who are serving now.

Since the Art and Hobby program and exhibit are suspended for the duration, each County President is requested to stress the importance of Medical History, promote interest in it and secure reports.

A Medical History Bulletin will be issued soon from the State Committee outlining plan and procedure. Full coöperation will be appreciated.

Mrs. Ily R. Beir  
3900 Atlantic Avenue  
Atlantic City

ADELE M. BEIR,  
Chairman.

## FINANCES

An alphabetical membership file is essential for each county. All information should be typed or printed.

The fiscal year of each County Auxiliary shall be from February 1st to January 31st of the following year. It is imperative that dues be forwarded to the State Treasurer immediately after February 1st.

Read carefully and follow the State Treasurer's "Suggestions to County Treasurers" mailed personally to each County Treasurer.

Mrs. Thomas P. McConaghy  
10th & Cooper Streets  
Camden

LOUISE M. MCCONAGHY,  
Treasurer.

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## NATIONAL BULLETIN

The National Bulletin gives the Auxiliary members an inclusive panorama of accomplishment and progress that stimulates new conceptions of service. Each achievement is a stepping stone to further success. That is true progress.

Let us strive for 100 per cent subscription in 1942-43—renew or become a new subscriber now.

Mrs. Samuel H. Jessurun  
613 High Street  
Newark

LILLIAN JESSURUN,  
Chairman.

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## WIDOWS AND ORPHANS

What is more fitting than having your husband join the Society for Widows and Orphans, and while protecting you and yours, at the same time helping along others less fortunate? No member has ever paid more into the Society than his widow or family received as a death benefit, which at the present time amounts to about \$430.00. Any widow of a member may call on the Society for help in time of need, as many have done in the past. Your County Chairman has full information and will be happy to pass it on to you.

Mrs. William D. Miningham  
18 Hedden Terrace  
Newark

EMMIE M. MININGHAM,  
Chairman.

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## LEGISLATION

Auxiliary members can do very effective work in Legislation, particularly this year with so many of the profession away from home doing war work and serving in the armed forces.

Keep up-to-date on legislation, both state and national, affecting public health and the medical profession. Obtain the point of view of the profession on such bills so that you can discuss them intelligently with the lay public in urging their passage or defeat. Emphasize the influence of individual or group letters sent to our state and national representatives.

A Legislative Bulletin will be issued soon from the State Committee. Please pass the information along to all members so that it can be used to the best advantage.

Mrs. Harry V. Hubbard  
121 East 7th Street  
Plainfield

VIOLA HUBBARD,  
Chairman.

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## HISTORY AND ARCHIVES

*"Small skill is gained by those who cling to ease;  
The able sailor hails from stormy seas."*

Since this is a war year, naturally the Woman's Auxiliary to The Medical Society of New Jersey will be striving in every way possible to aid our country in this dire time of need. These are grave days, and each one of us will have to do her part to help win the war.

Now, more than ever before, it is of the greatest importance that the Auxiliary keep an exceptionally accurate record of our activities, for that which is done this year will be significant and vital to the war effort.



Each County Historian is requested to prepare and forward to the State Chairman of History and Archives before the next Annual Meeting a copy of her Auxiliary's history. This data will be a permanent testimony of our effort and accomplishment. It will be filed in the Archives at the State Society Executive Offices in Trenton, in addition to the other important Auxiliary material—documents, reports, minutes, programs, albums, books, etc. From time to time, State Histories are compiled which find a place of security in the storehouse of National Headquarters at the American Medical Association.

Let us serve loyally and well.

Mrs. C. Chester Chianese  
464 Hamilton Avenue  
Trenton

CATHERINE F. CHIANESE,  
Chairman.

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### WAR PARTICIPATION

Since the entrance of our country in World War II, War Participation has taken the place of Medical Preparedness.

Already several of our County Auxiliaries are engaged in War Participation—collecting wool scraps for the Red Cross, acting as hostesses to Service Clubs, sponsoring Student Nursing Scholarships, etc.

In other counties because of geographical factors and transportation difficulties, our county members are working as individuals—coöperating with local defense units.

Wherever practical County Auxiliaries should work as groups. However, whether we work as groups or as individuals we should put forth our best efforts to aid in the winning of the war.

Those members with special qualifications, as shown by the survey conducted last year, can best serve in their own field. Those not specially trained are also needed in various capacities, and it is up to us to do our part.

Mrs. Dean H. LeFavor  
619 Morgan Avenue  
Palmyra

MINA P. LEFAVOR,  
Chairman.

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### PRESS AND PUBLICITY

The purpose and responsibilities of the County Press and Publicity Committee are as follows:

1. Immediately following each meeting send a concise report of the regular and special activities of your Auxiliary to the Editor of The Journal, The Medical Society of New Jersey, 222 West State Street, Trenton.

Reports are to be typed or printed on letter-size paper (8½ x 11), using one side only. Sign each report as Chairman of Press and Publicity or Reporter (sample report below).

2. Provide each important newspaper in the county with publicity on all regular and special activities of your Auxiliary.

Each Press and Publicity Committee should consist of about five members, living in different localities, so that the work may not become a burden on any one member, and all sections will be covered.

3. Collect two sets of newspaper clippings from all papers in the County that pertain to Auxiliary functions or meetings of lay groups in which the Auxiliary or physicians are participating.

Send one set of clippings, immediately upon publication, to the State Chairman for the State Scrap Book; keep the duplicate clippings for the County Scrap Book.

Be sure to date each clipping and designate the name of the paper (New York Times, Saturday, Sept. 7, 1942).

4. Furnish the State Chairman two weeks in advance with a copy of each monthly program.

5. Send a written report of the year's activities of the Press and Publicity Committee to the State Chairman not later than April 1, 1943.

Use letter-size typing paper and make the report a brief summary of publications, papers used, etc.

Mrs. Francis A. Macaulay  
815 Elm Avenue  
Teaneck

FLORENCE MACAULAY,  
Chairman

## COUNTY AUXILIARY REPORT FOR THE JOURNAL

The (regular or special) meeting of the Woman's Auxiliary to the —— County Medical Society was held (when) —— with —— presiding. There were (number) —— members present and (number) —— Auxiliary guests from other county auxiliaries.

Reports were received from (list the name of the report and by whom given). Mention particularly the work of the Program, Public Relations, Medical History and Widows and Orphans Committees.

State your program for the day (speaker and subject).

State what other educational material was used for the enlightenment of your Auxiliary members, such as: Book Reviews, Short Articles on Health Education.

State whether your meeting was followed or preceded by luncheon, tea, music or bridge.

Reported by:

Date: .....

.....  
Chairman or Reporter

## COUNTY MEETINGS

Atlantic—2nd Friday, October, November, January through May; Christmas Party, December; Annual Meeting, May.

Bergen—2nd Tuesday, October through May; Annual Meeting, May.

Burlington—1st Monday, November, March and May; Annual Meeting, May.

Camden—1st Tuesday, October, January, March; Annual Meeting, May.

Cape May—1st Tuesday, November, January, March and May.

Essex—4th Monday, October through May; Annual Meeting, May.

Gloucester—3rd Thursday, October through May; Annual Meeting, May.

Hudson—1st Monday, October through May; Annual Meeting, April.

Mercer—2nd Monday, November, January, February, April; Annual Meeting, May.

Middlesex—3rd Wednesday, October through June; Annual Meeting, December.

Ocean—1st Friday, October through May; Annual Meeting, May.

Passaic—3rd Monday, October, January, March, May; Annual Meeting, May; Reciprocity Meeting, April.

Somerset—2nd Thursday, October, December, February, April; Annual Meeting, June.

Warren—3rd Tuesday, October through May; Annual Meeting, March.

## OBLIGATIONS OF COUNTY PRESIDENTS

*Be prompt in your correspondence*

As a County President you are a member of the State Board. Publicize all State Meetings in your County and make an effort to attend. Present your yearly program at a State Meeting. All members are welcome.

## COUNTY PRESIDENTS

Atlantic	MRS. DAVID B. ALLMAN, Atlantic City
Bergen	MRS. HOWARD M. MEYER, Hackensack
Burlington	MRS. WILLIAM E. BRAY, Pemberton
Camden	MRS. HENRY R. TATEM, Audubon
Essex	MRS. ASHER YAGUDA, Newark
Gloucester	MRS. A. GUY CAMPO, Westville
Mercer	MRS. R. JOHN COTONE, Trenton
Middlesex	MRS. ROBERT B. WALKER, Highland Park
Ocean	MRS. EMANUEL M. SICKEL, Lakewood
Passaic	MRS. JOSEPH R. JEHL, Clifton
Somerset	MRS. WILLIAM J. ALBRECHT, Somerville
Warren	MRS. FLOYD A. SHIMER, Phillipsburg

## STATE CALENDAR

October 12, 1942—State Meeting—Trenton  
February, 1943—Send County Dues to State Treasurer  
March 9, 1943—State Meeting—Camden  
April 1, 1943—Annual Reports due  
May, 1942—Annual Meeting—Newark

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MRS. FRANK N. HAGGARD ..... 615 East Olmos Drive, San Antonio, Texas

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MRS. OSWALD R. CARLANDER .....		Camden	



## BOOKS RECEIVED FOR REVIEW

**NASAL MEDICATION;** a practical guide. By Noah D. Fabricant, M.D., M.S. Pp. 122. Baltimore, Williams & Wilkins Company. 1942. \$2.50.

**CONSTITUTION AND DISEASE;** applied constitutional pathology. By Julius Bauer, M.D. Pp. 208. New York, Grune & Stratton, Inc. 1942. \$3.50.

**MANUAL OF DERMATOLOGY,** issued under the auspices of the Committee on Medicine of the Division

of Medical Sciences of the National Research Council. By Donald M. Pillsbury, M.D., Marion B. Sulzberger, M.D., and Clarence S. Livingood, M.D. Pp. 421. Philadelphia, W. B. Saunders Company. 1942. \$2.00.

**FUNDAMENTALS OF PSYCHIATRY.** By Edward A. Strecker, M.D., Sc.D., F.A.C.P. Pp. 201. Philadelphia, J. B. Lippincott Company. 1942. \$3.00.

## BOOK REVIEWS

**The Essentials of Emergency Treatment.** Published by the Connecticut State Medical Journal, New Haven, Conn. Pp. 146.

The Connecticut State Medical Journal has recently issued a 146-page booklet entitled "The Essentials of Emergency Treatment". The Editor, Dr. Samuel C. Harvey, briefly states in the introduction the purpose of the booklet, i.e., "to present the present-day viewpoint in the treatment of injuries", and the scope of its content as "summaries rather than treatises". In the following ten pages the Organization and Function of the Emergency Medical Service in Connecticut is described in some detail. This organization is quite similar to that provided in New Jersey, and probably in other states, and includes the services of the private physician in his office as well as those of his colleagues who serve in group plans in hospitals and other medical centers.

The remaining pages are devoted to the strictly professional discussion of ways and means for combating the specific conditions found to exist in the various types of injury in the various parts of the body and bodily systems involved. These specific problems are described in such a concise way as to bring the essential principles to the general practitioner and to state clearly the immediate aims to be sought, without burying these points in less essential detail. The contributors have been well chosen and have provided references for a more detailed study by the general practitioner when and if needed, as the time permits.

This booklet is intended for physicians in general practice and properly lays greatest stress on their professional services to which is devoted the preponderant part of its pages. It also properly recognizes the important fact that the physician's services do not actually begin until physician and patient are in *contact*. In emergencies these contacts cannot always be made upon the patient's own initiative. For greatest value to the community is required a definitely organized and operated system involving facilities to insure transportation, adequate supplies, preventive education, identification, supervision, recording, feeding, housing and many other types of emergency service and that each type be adequately and properly rendered by those especially trained for these purposes. It is not only essential to bring physician and patient together, but also to permit the physician to confine his efforts within his most effective scope of professional function.

Congratulations to the Connecticut State Medical Journal for this pertinent and useful contribution and to the contributors who have made it possible.

L. A. WILKES, M.D.

### **National Formulary. National Formulary VII.**

Prepared by the Committee on National Formulary by authority of the American Pharmaceutical Association. Official from Nov. 1, 1942. 7th ed. Pp. 690. Washington, D. C., American Pharmaceutical Association. 1942. \$6.00.

Completely revised and enlarged, this edition represents a continuous program adopted by the committee to keep up to date the advances of pharmacy in relation to medical progress. It represents a cross-section of the prescriptions used in various sections of the U. S. A. and foreign possessions, in medical, dental and veterinary medicine. It includes reagent stains, culture media, staining solutions for bacteriological examinations, chemistry and biochemistry with laboratory methods.

It is important that the physician should specify his prescriptions by the capitals (NF) to assure uniformity of renewals. Many preparations of the NF are sold as proprietary preparations by pharmaceutical manufacturers. For instance linimentum album (NF), the common name of which, white liniment, is sold at retail pharmacies labeled "not NF" and contains one or more ingredients of the original NF preparation, thus losing the real purpose of the preparation, and becomes misleading to the public.

The National Formulary has listed drugs and chemicals that have been discarded by the U. S. Pharmacopeia. It would be a more useful work if this policy was discontinued and the scope of the volume confined to the purpose for which it was originally intended, leaving the standardization, assays and purity of all drugs to the U. S. P. Committee.

The formulary represents pharmacy's contribution to medicine and can be recommended to hospital internes, medical students and physicians as a guide to ethical drug therapeutics, and should discourage the prescribing of many proprietary medicines that eventually lead to self-medication by the general public. Its usefulness and popularity might be enhanced by once again publishing a condensed physicians' epitome of the most important seasonal remedies, a short resumé of prescription writing, a table of incompatibilities and solubilities and a complete section of poisons and antidotes.

LOUIS SIMONSON, M.D.

**Cabot and Adams Physical Diagnosis.** 13th ed. Edited by F. Dennette Adams, M.D. Pp. 888. Baltimore, Wm. Wood, The Williams & Wilkins Co. 1942. \$5.00.

It would be difficult to find a more complete single volume than Cabot and Adams Physical Diagnosis, now in the 13th edition. Any text book that calls for repeated editions, and for repeated printings of those new editions, has already proven its value.

This edition covers the subject in a masterly and concise way, from the many points to be considered in taking histories, through all the innumerable conditions that are encountered by the general practitioner.

We hear much of "refresher courses" in medicine. This book in itself constitutes such a course for the many physicians who, with all the demands now being made upon them, cannot take time out to attend a series of lectures.

SAMUEL BARBASH, M.D.

**Synopsis of Materia Medica, Toxicology, and Pharmacy for Students and Practitioners of Medicine.** By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B. 2d ed. Pp. 695. St. Louis, C. V. Mosby Co. \$5.57.

Dr. Davison's synopsis consists of 669 pages of compendious material, flexibly bound with a fitting choice of paper and print into a handy volume. An adequate bibliography is appended to each chapter. Throughout there is a welcome freedom from typographical errors.

Only a chemist may ask for a more accurate indication of the structural formulas in the chapter on the sulfonamides—the only place where they are not presented with utmost accuracy.

In reading the section devoted to alcohol, it is difficult to avoid astonishment at the confusion that still persists on this simplest and most familiar of all organic compounds. A suspicion arises that this matter will not be settled until "the tumult and the shouting" of ethical concepts surrounding its use "have died".

As an example of detailed scholarship we have a product which leaves nothing to be desired. In contrast, as a guide for discriminating choice to therapeutic measures, it lacks many guiding principles.

It is interesting to note Dr. Davison's disposition in this synopsis to pass occasional judgments on the newest treatments, leaving sacredly untouched the estimate of drugs which have been used for millenia.

SAMSON FREIMAN,

Professional Service Representative  
E. R. Squibb & Sons.

**Demonstrations of Physical Signs in Clinical Surgery.** By Hamilton Bailey, F.R.C.S. Eighth edition, revised. Pp. 336. Baltimore, The Williams & Wilkins Company. 1942. \$7.00.

Hamilton Bailey's *Demonstration of Physical Signs in Clinical Surgery* needs no introduction to the medical profession. The series of editions and reprints which extend from 1927 to a reprint of

the seventh edition in December, 1940, would have been brought to an untimely end by the unfortunate destruction of many of the illustrations by enemy action, had not the author applied himself to the prodigious task of reassembling the book in which he has done admirably well.

The illustrations are excellent and informative. Anyone who is unduly impressed with the importance of the laboratory would do well to learn from this book what the use of the five senses can accomplish. We often stress the importance of an adequate history, but the development of observing eyes, keen ears, and sensitive fingers is equally important.

The last chapter of the book consists of one and one-half pages with a single illustration of a man's back on which we find in dermographic writing, "There'll always be an England."

The appearance of a new edition at this time is a tribute to the undaunted efforts of both author and publisher.

C. ABBOTT BELING, M.D.

**Care of the Aged (Geriatrics).** By Malford W. Thewlis, M.D. 4th ed. St. Louis, C. V. Mosby Company. 1942. \$7.00.

Every internist has found that within the last decade the average age of his patients has increased, and that many of those fifty years and over have to be eased over the ailments coincident with advancing years, often when there are no objective findings. The many text books useful in other cases do not always fill the need when one turns to them for help in treating aged and aging patients.

Dr. Thewlis' last edition covers clearly and concisely the large range of general subjects that arise in geriatrics, including some medico-legal aspects and some of the more obscure and infrequent conditions. The book is especially useful in understanding the mental, physical and psychological problems attendant upon age. In the present-day need for economic conservation and putting all available skill at work, one cannot overlook the importance of helping those of advancing years to add their quota of experience for the general good.

SAMUEL BARBASH, M.D.

**Psychology of Dealing with People;** serving the need of a feeling of personal worth. By Wendell White, Ph.D. 2d ed. New York, The Macmillan Company. 1942. \$2.50.

A careful reading of this book will help us polish off some of our corners. It gives a good resumé of the inhibitions we should cultivate if we desire to be liked by those around us. The book should be of great value to the generation who overdid Freud and tried to live an inhibitionless existence.

**I'm Gonna Be a Father!** By Bob Dunn (With a Little Assistance from His Wife). Philadelphia, David McKay Company. 1941. \$1.00.

A presentation in picture form of the complications of being a father.

# TUBERCULOSIS ABSTRACTS

## *A Review for Physicians*

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A SECOND five-year review of tuberculosis in college students, marking the close of a decade of service by the Tuberculosis Committee of the American Student Health Association, reveals heartening progress, along with the stern challenge that tuberculosis still clings tenaciously to first place among causes of death in those of college age. Three hundred and four colleges and universities reported tuberculosis programs for 1940-41 as against 104 in 1936-37, but this represents a bare 36% of American institutions of higher education. Ancient and erroneous notions about tuberculosis still persist in the minds of many college administrators which unhappily limit the adequacy of their college health services. The truth must be carried to these people ceaselessly and convincingly, if we are to dislodge tuberculosis from the American college campus.

### TUBERCULOSIS IN COLLEGE STUDENTS

The Tuberculosis Committee of the American Student Health Association was formed in 1931 following the First National Conference on College Hygiene at Syracuse University. At that time six institutions of higher education were known to have begun tuberculosis programs—the state universities of Minnesota, Michigan and Pennsylvania and Western Reserve University, Vassar and Yale. At the close of the first five years of the Committee's work, 50 colleges reported programs. Now, at the end of the second five years, 304 institutions so report. This number represents every section of the country, and includes endowed colleges and universities; state colleges, institutes, teachers' colleges and universities; and civic colleges and universities. State universities make the best showing; the small, privately endowed colleges the least satisfactory, as shown in the following table:

In 1936-37 there were 91 colleges using the tuberculin test on 56,224 students; in 1940-41, 255 colleges were doing so, and the number of students taking the test had increased to 149,744. The percentage of institutions using the Mantoux method has dropped in this period from 88% to 82%. Recent experiments in some localities with Patch testing, along with some schools using the Pirquet method because the state supplies only that type of testing material, account for the drop.

The number of colleges using routine chest films without prior tuberculin testing has increased from 12% in 1936-37 to 16% in 1940-41. A few colleges and universities have adopted miniature film mass surveys.

There has been an encouraging increase in the number of colleges examining non-student personnel. In 1936-37, 30 colleges required the ex-

*Number of colleges with tuberculosis programs*

TYPE OF INSTITUTION	1936-37	1937-38	1938-39	1939-40	1940-41	RATIO OF INCREASE
Endowed colleges .....	36	41	58	105	118	3.3
Endowed universities .....	8	14	20	20	35	4.4
State universities .....	15	19	24	30	36	2.4
State colleges and institutes .....	12	18	19	22	35	2.9
State teachers' colleges .....	31	38	37	65	70	2.3
Civic colleges and universities .....	2	3	7	6	10	5.0



amination of food handlers and 29 the examination of faculty and administrative employees, while in 1940-41 there were 108 colleges reporting the examination of food handlers and 92 the examination of faculty and administrative personnel.

The annual reports of the Tuberculosis Committee have disclosed a startling difference in the amount of tuberculosis in students discovered in colleges with case-finding facilities and in schools with no program of case finding. In this second five-year period, 1936-41, the colleges in the latter category reported the discovery of 184 new cases of tuberculosis among a student enrollment of 668,895, or 27.5 per 100,000. The colleges with case-finding facilities reported the discovery of 3,523 new cases in a student enrollment of 1,850,755, or a rate of 190.5 per 100,000, during the same period.

Roughly, this confers a ratio of seven-to-one in favor of the progressive colleges dedicated to the proposition that tuberculosis must be tracked down to its lair, found early, treated promptly, if it is to be defeated ultimately in the individual and in the nation. These figures imply that thousands of cases of tuberculosis, many of them infectious, are being harbored and ignored among American college students through utter failure of most colleges to comprehend that a threat to health truly exists and that a major social and economic problem clamors for action.

Letters from college administrators attempting to justify the non-existence of case-finding programs in their respective institutions indicate the prevalence of such ancient ideas as, that only when "consumption" arrives is tuberculosis present, that early tuberculosis can be ruled out by a

doctor's cursory certification, or by stethoscopic search, or by stratified social selection. The survival of these fallacies among educated people represents our failure to carry the truth ceaselessly and convincingly to every person whose information, no matter how complete in most directions, remains barren with respect to tuberculosis.

The war, which brings in its train conditions of overcrowding and overwork, the disruption of public and private medical services, the curtailment of budgets and restriction of personnel, gives opportunity also for the increase of tuberculosis unless special efforts are made to guard against this menace. Army, Navy, industry, public health—all must fight together and against tuberculosis, but it is of the very essence and function of education that colleges and universities lead the battle.

It is suggested that just as counties were once accredited for eliminating tuberculosis from their dairy herds, even as today they are being accredited in Minnesota for driving death rates and infection rates to low levels, colleges and universities might be accredited by the American Student Health and the National Tuberculosis Associations, once they have inaugurated and maintained acceptably a modern program against student tuberculosis. Laggard colleges might thus be tempted to make the necessary adjustments so that they could be listed on the Roll of Honor of progressive, public-spirited institutions.

The war must go on. The war must be won and we must win it, both from our external foes and from such borers-from-within as tuberculosis.

*Tuberculosis in College Students, Charles E. Lyght, Amer. Rev. of Tuber., Sept., 1942.*

SUPPLIED BY

NEW JERSEY TUBERCULOSIS LEAGUE

15 East Kinney Street, Newark, New Jersey

# INDEX---1942

## A

Abdomen, Acute Diseases of, and of the Chest,  
Differential Diagnosis Between—Muller.... \*27  
Abdomen, Acute, in Infancy—Murray ..... \*617  
Abdominal Pain of Urologic Origin in Children  
—Campbell ..... \*427  
Abel, Arthur R., West Orange ..... 109, \*439  
Abel, Margaret ..... 553  
Abortion, Recurrent and Threatened. Treatment  
of—Carrington ..... \*387  
Abortion, The Treatment of—Bingham ..... \*624  
About Ourselves (J. G. Needham) ..... br51  
Academy of Medicine of Northern New Jersey.. 41  
Accelerated Program of Medical Schools..... ab379  
Accidental Injuries (H. H. Kessler) ..... br52  
Achievement Is the Yardstick ..... 42  
Address Change of The Medical Society ..... 598  
Adult Health Supervision Advisory Commit-  
tee ..... 102, 103, 549  
Adulteration of "Dope" Peddled in Illicit Traffic 343  
Advisory Committees and Personnel ..... 549  
Affirmative Program, An ..... e2  
Aged, Care of the (Geriatrics) (M. W. Thew-  
lis) ..... br660  
Air-Raid Strain ..... ab484  
Air Raids, Medical Defense During ..... 136  
Alexander, John ..... 291  
Alexander, Samuel ..... 114, 650  
Allergy—  
In Clinical Practice (Cleveland Clinic) .... br125  
Round Table Discussion on ..... 511  
Synopsis of (H. L. Alexander) ..... br611  
Allocation of Physicians ..... 631  
Ambulance for Prematures ..... 103  
Ambulance School bus ..... 260  
Ambulatory Patient, Surgery of the (Ferguson  
and Kaplan) ..... br612  
American College of Surgeons Approved Hospi-  
tals ..... 141  
American Medical Association—  
Annual Meeting (1942):  
No Valid Reason to Move Inland ..... 290  
Report on ..... 391  
Annual Meeting (1943) ..... 557  
Case ..... 512, 598  
Delegates (Advertising p. 3A each issue of *The  
Journal*)  
Secretaries' and Editors' Conference ..... 639  
American Red Cross Sends Drugs, Medical Sup-  
plies to Russia ..... 403  
Amphetamine (Benzedrine) Sulphate and Thy-  
roid Extract in the Treatment of Obesity—  
Kalb ..... \*74  
Amphetamine (Benzedrine) Sulphate, the Ef-  
fect of, Propadrine Hydrochloride and Pro-  
padrine Hydrochloride in Combination with

Sodium Delvinal on the Appetite of Obese  
Patients—Kalb ..... \*584  
Andrews, Clarence L., Atlantic City ..... \*424  
Anemia, Pernicious, Erythremic Response to  
Liver Therapy—Ferrary ..... \*19, 166  
Angina, Nocturnal—Rubin ..... \*529  
Anginal Pain Due to Adhesive Pericarditis—  
Eigen and Abel ..... \*439  
Annual Congress on Industrial Health ..... 633  
Annual Meeting, the 176th ..... 137, 288  
Dinner Dance Reservation ..... 137  
Exhibits ..... 243  
Program ..... 137, 238  
Scientific Motion Picture Theatre ..... 242  
Section Meetings ..... 239  
Sessions:  
General Medical ..... 239  
General Surgical ..... 239  
Transactions ..... \*415  
Annual Meeting (1943) Meeting Place ..... 506  
Annual Registration ..... 95, 106, 111, 170, 171  
Also see Transactions  
Annual Reports to the House of Delegates ... e183  
Index ..... 184  
Notice of ..... 108  
Officers, Committees and County Societies.185-235  
Ano-Rectal Diseases, Synopsis of (L. J. Hirsch-  
man) ..... br462  
Ano-Rectal Pain, Causes and Treatment—Ger-  
endasy ..... \*21  
Answers to Certain Important Questions ..... 571  
Antopol, William ..... 291, 601  
Apoplexy and Low Blood Pressure ..... ab146  
Appendicitis, a Better Technic in Operating  
for ..... ab493  
Appendicitis and the General Practitioner—  
Schaaf ..... \*76  
"Argyria" Case in Young Female Due to Over-  
administration of a Colloidal Silver Prep-  
aration—Gordon ..... \*441  
Armed Forces' Need for Physicians ..... 471  
Armstrong, Janet G. .... 118  
Armstrong, Robert R.† ..... 293  
Army Appointments (Medical Department) ... 252  
Army-Navy "E" Given Red Cross Blood Donor  
Service ..... 523  
Arsenotherapy, Intensive, of Syphilis in New  
Jersey Hospitals—Roemer ..... \*498  
Arthritis, Chronic, X-Ray Therapy of (K. Gold-  
hamer) ..... br51  
Arthritis in Modern Practice (J. G. Kuhns)... br305  
Atlantic County Medical Society.... 43, 114, 168,  
295, 346, 404  
Attention: Physicians ..... e361  
Auer, O. R. .... 117  
Automobile, The Doctor's ..... 67  
Automobile Tires, Purchase of ..... 67

\* Original article  
† Obituary  
ab—Abstract  
e—Editorial

br—Book review  
Annual Reports: April Journal  
Official List: May Supplement  
Transactions: August Supplement

Autonomic Nervous System (White & Smith-wick) .....	br179
Auxiliary Medical Services Advisory Committee .....	99, 107, 549
Average Length of a Generation .....	ab484
Aviation Medicine .....	260
Awards for Scientific Exhibits .....	289

**B**

Babcock, W. Wayne .....	43, 170, 300
Baehr, Col. George .....	573
Bailey, Cameron V. ....	396
Baker, Charles F., Newark .....	291, *575
Bandaging, Splinting and Strapping Manual (A. Thorndike) .....	br50
Bang, Frederick B. ....	553
Barbano, A. J., New Brunswick .....	109, *383
Beadleston, Alfred .....	117
Beardwood, Joseph T., Jr. ....	168
Behind the Mask of Medicine (M. Atkinson) .....	br306
Beling, C. Abbott .....	109, 291
Bell, Joseph A., Bethesda, Md. ....	*419
Bell Telephone Company Booster .....	ab504
Benjamin, Harold C. ....	160
Bercovitz, Zachariah .....	114
Bergen County Medical Society .....	43, 114, 168, 560
Bernhard, William A. ....	291
Bernstein, Arthur .....	396, 601
Beveridge, William W.† .....	402
Bick, Edgar M. ....	291, 601
Biliary Dyskinesia—Barbano .....	*383
Bingham, Arthur W., East Orange .....	*33, *35, *87, *90, 109, *151, 160, 291, *339, 351, *386, *449, *504, *539, *547, *586, *624, *629
Biochemistry, Comparative, Intermediate Metabolism of Fats, Carbohydrate Metabolism. Biochemistry of Choline (edited by H. B. Lewis) .....	br461
Bismuth Efficiency, Increasing .....	ab435
Blood—	
And Plasma Program .....	472
Bank and the Technique and Therapeutics of Transfusion (Kilduffe and DeBaKey) .....	br308
Coagulation, A Simple Method of Timing—Knauer .....	*75
Collections for Army and Navy .....	259
Diseases of the, and Atlas of Hematology (R. R. Kracke) .....	br357
Donor Service, Red Cross, Given Army-Navy "E" .....	523
Grouping Technic (Schiff and Boyd) .....	br564
Human, Transporting of .....	ab327
Preparation Film .....	349
Pressure, Low, and Apoplexy .....	ab146
Tests on Registrants .....	67
Bombs and Neuroses .....	67
Bongiorno, Henry D. ....	54
Book Reviews .....	49, 123, 179, 304, 357, 411, 461, 513, 563, 611, 659
(Listed alphabetically by title in general index and marked br)	
Books for Men in Service .....	260

Booster .....	ab504
Botanical Drugs .....	163
Bourgeois, George A. ....	553
Boyer, Paul K. ....	396
Brakeley, Elizabeth .....	507, 601
Branch, W. Harold .....	601
Bristol, Leverett D., New York, N. Y. ....	506
British-American Ambulance Corps .....	ab484
Bronchial Asthma, Emotional Factors in—Halman .....	*80
Brown, Richard J.† .....	164
Browning, W. Kempton† .....	165, 346
Bruger, Maurice .....	649
Brussel, James A., Fort Dix .....	*442
Budget (See Transactions)	
Bulletin Board .....	53, 113, 167, 294, 345, 403, 460, 511, 557, 604, 646
Bunney, William Edward .....	507
Burlington County Medical Society .....	43, 115, 169, 295, 346, 404, 560, 606, 647
Burnham, Lyman .....	109
Burns, Local Treatment of .....	ab386
Butler, Eustace † .....	344

**C**

Cabot and Adams Physical Diagnosis (edited by F. D. Adams) .....	br660
Call to the Colors .....	5
Camden County Medical Society .....	43, 295, 346, 404
Campbell, Meredith F., New York, N. Y., and Montclair, N. J. ....	343, 349, *427
Canada Controls the Sale of Paregoric .....	ab265
Cancer—	
Of the Face and Mouth (Blair, Moore and Byars) .....	br124
Of the Rectum, Some Problems in the Management of—Silvers .....	*323
Reportability of .....	102
Cannon, E. A. ....	553
Cantarow, A. ....	396
Cape May County Medical Society .....	169
Carcinoma and Other Malignant Lesions of the Stomach (Waters, Gray and Priestley) .....	br514
Carcinoma of the Cervix, Urinary Tract Pathology Associated with—Markowitz and Katz .....	*373
Cardiac, Neurosis, Recognition and Management of—Wolfe .....	*266
Cardio-Vascular Advisory Committee .....	549
Cardiovascular Cases, Placement of, in Industry—Greenberg .....	*147
Car-Driving Patients Questionnaire .....	108
Cardwell, Edgar P. ....	507, 553
Care of the Indigent as a "By-Product" .....	e312
Carlisle, J. M. ....	450, 552
Carpenter, Cedric C. ....	160, 507
Carrigan, Frank .....	54
Carrington, William J., Atlantic City .....	131, *387
Cause and Effect .....	e567
Cecil, Russell L. ....	298
Cerebellar Abscess of Otogenic Origin, Recovery from—Moriconi .....	*385



- Cesarean Operation and the New Jersey Maternal Welfare Report—MacKenzie .....\*280  
Charaka Club, Proceedings of .....br305  
Cheifetz, Sonia ..... 647  
Chemical Warfare Agents ..... 318  
Chemotherapy in War Time, on the Possibilities and Practice of—Lockwood .....\*479  
Cherry, Homer H. ....46, 291  
Chesley, Elizabeth R. .... 109  
Chesley, Leon C. .... 109  
Chest, Acute Diseases of, and of the Abdomen, Differential Diagnosis Between—Muller ...\*27  
Chest Conference ..... 115  
Chest Physicians, New Jersey Chapter of the American College of ..... 343, 511, 650  
Child Health Advisory Committee .....158, 549  
Child Health Day Proclamation ..... 162  
Childbirth Accidents—Bingham .....\*33  
Children—  
    Abdominal Pain of Urologic Origin in—Campbell .....\*427  
    In Defense of (B. I. Beverly) .....br358  
    Taking Care of the ..... 572  
Children's Feet ..... 596  
Chinese Lessons to Modern Medicine (I. Snapper) .....br307  
Churg, Jacob ..... 291  
Circulation Time and Venous Pressure—Klein .....\*144  
Civilian Medical Defense in New Jersey ..... 9  
Civilian Medical Practice on a War Time Basis 365  
Clark, Josephine D. .... 553  
Clinic Service, Medical .....e362  
Clinical Application of the Rorschach Test (Bochner and Halpern) .....br308  
Clinical Immunology, Biotherapy and Chemotherapy in the Diagnosis and Treatment of Disease (Kolmer and Tuft) .....br304  
Clinical Surgery, Demonstrations of Physical Signs in (H. Bailey) ..... br660  
Clinico-Pathologic Conferences at Newark City Hospital ..... 637  
Clinics, Vol. 1, No. 1 (edited by G. M. Piersol) br514  
Cohen, Samuel ..... 291  
Cohn, George M. .... 601  
Coley, Bradley L. .... 172  
Colwell's Daily Log for Physicians (Dr. Colwell) .....br611  
Comando, Harry N. .... 553  
Committee—  
    Meetings .....590, 630  
    Members, Current List of, Announcement .. 506  
    Reports (See special index, p. 184)  
    Work for the Year ..... e517  
Committees, List of (Advertising p. 4A January, April and August and p. 549)  
Communicable Diseases Handbook (F. H. Top) br124  
Community Participation by the Physician .... e3  
Connecticut Medical Care .....ab586  
Connecticut State Medical Society Selects Medical Personnel ..... 162  
Conover, Ellsworth E.† ..... 164  
Conservation of Vision Advisory Committee.102, 104, 158, 161  
Constitutional Amendment, Proposed ..... 36  
Constructive Criticism ..... e568  
Consultant State Hospital Officer ..... 472  
Contract Practice Advisory Committee .....101, 549  
Convalescent Children, Play for, in Hospitals and at Home (A. M. Smith) .....br411  
Cook, Hugh F., Newark .....\*142  
Coöperating Organizations (Advertising p. 3A January, April and August)  
Cosgrove, S. A. .... 160  
Councilor District, Fifth ..... 295  
Councilors, List of (Advertising p. 3A each issue of *The Journal*)  
County Society—  
    Bulletins ..... e129  
    Meeting Dates ..... 559  
    Reporters ..... 605  
Crippled Children Advisory Committee ..... 549  
Cumberland County Medical Society .. 44, 170, 346, 647  
Cummins, George W.† .....54, 293
- D**
- D'Alessandro, Arthur J. ....160, 507  
Dark Legend (F. Wertham) ..... br126  
Davenport, Peter B.† ..... 344  
Davidson, Harold S. .... 109  
Davidson, Henry A., Newark .....167, 349, \*380  
Davis, John E. .... 167  
Death Certificates in Childbirth, Lessons from—Bingham  
    No. 37 .....\*35  
    No. 38 .....\*90  
    No. 39 .....\*151  
    No. 40 .....\*284  
    No. 41 .....\*339  
    No. 42 .....\*386  
    No. 43 .....\*449  
    No. 44 .....\*504  
    No. 45 .....\*547  
    No. 46 .....\*586  
    No. 47 .....\*629  
Deceased Physicians, Table of, by Months.165, 402, 603, 645  
Decontamination of Eyes After Exposure to Lewisite and Mustard ..... 366  
DeGrace, Frank ..... 54  
Deibert, Irvin E., Camden .....\*319  
Delegates, House of, 1942 Annual Meeting, Executive Officer's Abstract ..... 451  
Denbo, Elic A. .... 167  
DeOreo, Gerard ..... 508  
Dermatological Society, Northern New Jersey .....175, 353  
deVincenzo, F. R. .... 553  
Diabetes Among Jews .....ab52  
Diabetes Mellitus (Wirtschafter and Korenberg) .....br307  
Diarrhea, Infantile, Sulfathiazole in .....ab330  
Diathermy and Vasodilatation .....ab487  
Diet in Sinus Infections and Colds (E. V. Ullmann) .....br308  
Diethylstilbestrol, Intolerance to .....ab410

- Digitalis .....ab504  
 Dilger, Frederick ..... 54  
 Dinger, Ferdinand C., East Orange .....\*30, 160  
 Diphtheria and Whooping Cough, Simultaneous  
 Immunization Against .....ab441  
 Diuresis, Early, in Congestive Heart Failure—  
 Andrews ..... \*424  
 Doctor and the Army—Kilduffe ..... 5  
 Doctor, One, Should Not Serve More Than 1500  
 People ..... 470  
 Doctor Takes a Holiday (M. McKibbin-Harper) .....br124  
 Doctor's Dilemma ..... e59  
 "Dope" Peddled in Illicit Traffic, Adulteration  
 of ..... 343  
 Draft Board's Lament .....ab497  
 Dreskin, O. Herman, Newark .....\*473  
 Dreyfuss, Leonard ..... 573  
 Drug Monopoly Seen as Threat to Control of  
 Malaria ..... 258  
 Drugs, Botanical ..... 163  
 Drury, Alfred J.† ..... 165  
 Dues ..... e364, 638  
 Duodenal and Gastric Ulcers and Gall-Bladder  
 Diseases—When Medical and When Surgi-  
 cal—Kraemer .....\*270
- E**
- Eagleton, Wells P., Newark .....\*68, 291, 396  
 Echo from the 1924 Annual Meeting ..... 236  
 Eckerson, Edwin ..... 300  
 Economy ..... e313  
 Egg Yolk Powder .....ab269  
 Ehler, Adrian E. .... 291  
 Eigen, Louis A., West Orange .....\*439  
 Eisenberg, David ..... 54  
 Electrotherapy and Light Therapy, with the Es-  
 sentials of Hydrotherapy and Mechano-  
 therapy (R. Kovacs) .....br563  
 Elwood, B. J. .... 292  
 Emergency Base Hospital No. 1 ..... 469  
 Emergency Medical Field Units Equipment.... 65  
 Emergency Medical Service Report ..... 255  
 Emergency Treatment, Essentials of (Conn.  
 State Med. Jrl.) .....br659  
 Emotional Factors in Bronchial Asthma—Hai-  
 man ..... \*80  
 "Enemy X" Film ..... 604  
 Enrollment Form for Physicians ..... 4  
 Enteritis, Segmental—Robbins and Dreskin....\*473  
 Epidemiology in War Time—Bell .....\*419  
 Equipment for Emergency Medical Field Units. 65  
 Ergot in Thyrotoxicosis .....ab279  
 Erythremic Response of Liver Therapy in  
 Treatment of Pernicious Anemia—Ferrary  
 .....\*19, 166  
 Essentials of Applied Laboratory Technique  
 (Feder and Elliott) .....br304  
 Essex County Medical Society .. 115, 170, 296,  
 347, 405  
 Essex County Town Hall Program ..... 558  
 Evans, William E., Jr. .... 553
- Exchange of Views .....e364  
 Executive Officer's Page .....505, 548, 590, 630  
 Purpose of .....e467  
 Eye—  
 Diseases, Manual for Students and General  
 Practitioners (C. H. May) .....br179  
 Hazards in Industry (L. Resnick) .....br125  
 Manifestations of Internal Diseases (I. S. Tas-  
 man) .....br461  
 Eyesight of the Worker—Sherman ..... 161
- F**
- Fact, Functional or Fake, the Neuropsychiatric  
 Problem of the Army—Brussel .....\*442  
 Falkenburg, L. W. .... 350  
 Fanburg, Sol ..... 54  
 Farm Security Medical Care Plan ..... 638  
 Fellowships in Medicine and Public Health .... 512  
 Felt ..... 345  
 Femur, Fracture of the Neck of the; Rapid  
 Nailing .....ab493  
 Ferrary, Paul B., Totowa .....\*19, 160  
 Fibrositis, Vitamin Treatment of .....ab141  
 Films, Health ..... 604  
 Finance and Budget Committee ..... 638  
 Finkler, Rita S. ....160, 507, 601  
 Firm Foundation, A .....e465  
 First Aid Dressing ..... 418  
 Fischelis, Robert P. .... 134  
 Fishbein, Morris .....63, 91, 114  
 Fitz-Hugh, Thomas, Jr. .... 43  
 Flicker, David J. .... 553  
 Flippen, Harrison F. .... 171  
 Ford, Norma ..... 396  
 Forman, Sylvan E. .... 553  
 Foster, R. H. K. .... 292  
 Friedman, Milton ..... 507  
 Frumkin, Sylvia ..... 396  
 Fryczynski, Marya ..... 507  
 Functional Pathology (L. Lichtwitz) .....br126  
 Fund Donations to Health in 1940 .....ab438  
 Furst, Nathan J. .... 601
- G**
- Gall-Bladder Disease and Duodenal and Gas-  
 tric Ulcers—When Medical and When Sur-  
 gical—Kraemer .....\*270  
 Gall-Bladder Disease, Diagnosis of—Perkel....\*488  
 Gamon, Robert S. .... 109  
 Garner, Jay M. .... 343  
 Gasoline and the M.D. ....e616  
 Gastric, and Duodenal Ulcers and Gall-Bladder  
 Disease—When Medical and When Surgical  
 —Kraemer .....\*270  
 Gastroscopy and the General Practitioner—  
 Heineken .....\*138  
 General Hospital, Relation of the, to Psychia-  
 try—Gordon ..... \*84  
 General Practitioner and Appendicitis—Schaaf \*76  
 Genitourinary Diseases, Synopsis of (A. L. Dod-  
 son) .....br124

Gerber, Isadore E. ....	507, 601
Gerendasy, Julius, Elizabeth .....	*21, 160
Geriatrics (E. P. Boas) .....	br611
Geriatrics (M. W. Thewlis) .....	br660
Getting Results .....	e362
Gillespie, R. D. ....	67
Gingivitis, Treatment of .....	ab426
Glazer, Edward .....	117
Gloucester County Medical Society .....	44, 115, 170, 297, 348, 560, 647
Gnassi, Angelo M. ....	160, 291, 503
Goldberg, H. C. ....	109
Goldenberg, Raphael R. ....	292
Goldman, Lester M. ....	109, 343
Goldring, William .....	118
Goldstein, Hyman I. ....	109, 166, 343, 396
Gonorrhea, Acute, in Women, and Sulfonamid Suppository .....	ab273
Gonorrhea, Five Day Cure .....	294
Gordon, Benjamin Lee .....	343
Gordon, J. Berkeley, Marlboro .....	*84, 291
Gordon, Maurice B. ....	343, 553
Gordon, Milton H., Camden .....	*441
Gorten, Manfred L. ....	167
Government Coöperation or Control? .....	e519
Governor's Health Conference .....	103
Greenberg, Max .....	*147
Greenwood, W. Russell .....	396
Gregory, Roy A.† .....	459
Grosfeld, William .....	46
Gunshot Wounds of the Head, Record of .....	317
Cases .....	ab445
Gynecology, Pediatric (G. C. Schaufler) .....	br514

## H

Hagen, Walter H. ....	167
Haiman, J. A., New York, N. Y. ....	*80
Hallinger, Earl S. ....	111, 291, 509
Hamilton Farms Emergency Base Hospital No. 1 of New Jersey .....	469
Hargrave, Frank S.† .....	344
Haury, Victor G. ....	396
Hausssling, Francis R., Portrait of .....	37
Hawkes, E. Zeh .....	396, 397
Hawkes, Stuart Z., Newark .....	*328
Hay Fever Treatment .....	ab75
Health— Fund Donations in 1940 .....	ab438
Insurance .....	e363
Needs and Organization, New Jersey's, Study of .....	553
Officials, State and Municipal, Annual Meet- ing .....	159
State Department of— Aims and Activities .....	455
Annual Report .....	110
To Participate .....	8
Supervision and Prophylaxis Advisory Com- mittee .....	549
Heart— Committee and the Defense Program .....	109
Disease, Prevention and Control of, Advisory	

Committee .....	102, 103, 549
Failure, Congestive, Early Diuresis in—An- drews .....	*424
Heating and Health .....	595
Heineken, Theodore S. ....	*138, 160
Helpful Hints .....	469
Hemorrhage in Infants .....	ab431
Hernia. New Legislation on .....	344
Herrman, William .....	116
Hewson, George F. ....	*142
Hiccups in the New-Born .....	ab431
Hicks, William H.† .....	164
Hippocratic Medicine (W. A. Heidel) .....	br180
Hirschfield, B. A., Trenton .....	*494
History, An Outline, of our Society .....	110
History Repeats Itself .....	e249
Hollinshead, Ralph K. ....	647
Holm, August .....	508
Hospital in Civilian Defense—Hyde .....	12
Hospitalization and Medical Benefits for Vet- erans of World War II .....	594
Hospitalization and Medical Care, Temporary, Necessitated by Enemy Action to Civilians. ....	257
Hudson County Medical Society .....	171, 297, 348, 406, 561, 647
Hughes, Joseph .....	116
Hunterdon County Medical Society .....	171
Hyde, H. van Zile, New York, N. Y. ....	12
Hydrocele, Traumatic Rupture of—Cook and Hewson .....	*142
Hypophyseal Deficiency Resembling Simmond's Disease—Prout and Thompson .....	*376

## I

Ill, Carl L., Newark .....	173, *502
Ill, Edgar A.† .....	165
Ill, Edward J.† .....	402
Award to Dr. E. Zeh Hawkes .....	396
Resolution .....	554
I'm Gonna Be a Father (B. Dunn) .....	br660
Immunization Against Typhus .....	ab372
Immunization, Simultaneous, Against Diphtheria and Whooping Cough .....	ab441
Immunology (N. P. Sherwood) .....	br179
Immunology and Pathology, 1941 Year Book of (Karsner and Hooker) .....	br124
In Memoriam—LeRoy A. Wilkes, 1883—1942 .....	e615
Indigent Care .....	e312
Industrial and Orthopedic Surgery, 1941 Year Book of (edited by C. F. Painter) .....	br612
Industrial Health and Hygiene Advisory Com- mittee .....	100
Industrial Health, Annual Congress on .....	633
Industrial Medicine .....	450, 506, 552
Physicians in .....	522
Post-Graduate .....	597, 634
Infant and Child, Sick, Management of the (Porter and Carter) .....	br612
Infant Nutrition (W. M. Marriott) .....	br125
Infant Resuscitation .....	290
Infantile Paralysis, Grants for the Study of .....	345
	ab487



Infections, Wound—Diagnosis and Treatment— Deibert .....	*319	Levin, Philip .....	109
Infertile Pregnant Patient, Treatment of— Montgomery and Stewart .....	*333	Levy, Irvin, Trenton .....	*581
Initial Military Rank for Physicians .....	468	Levy, Julius .....	398
Insemination, Artificial .....	ab339	Levy, Robert .....	168
Instructors, Physicians as .....	15	Licenses, Temporary, to Practice the Healing Art in the District of Columbia .....	e520
Insulin Quality, Maintaining .....	40	Life and Liberty, In Defense of .....	573
Insurance, Health and Accident, Physicians' .....	42	Life Expectancy .....	ab423
Intelligence Plus .....	e60	Lights Have Gone Out, The .....	e1
Internal Medicine in Old Age (Mueller-DeHam and Rabson) .....	br461	Liver Therapy, Erythremic Response in Treat- ment of Pernicious Anemia—Ferrary .....	*19, 166
Internships and/or Residencies .....	521	Lockwood, John S., Philadelphia, Pa. ....	*479
Interstitial Keratitis—Sherman .....	*485	Loeser, L. H. ....	553
Iodine, Mild Tincture of, U. S. P. ....	418	Londrigan, Joseph F. ....	351
It Can Be Gallant Again .....	ab382	Look to the Future, A .....	e568
Itch to Write—Davidson .....	299, *389	Looking Forward .....	250
		Losado, Camella A. ....	109
		Lucchesi, Pascal F. ....	296

## J

Jacobs, Lewis .....	292
Jaffin, Abraham E. ....	508
Jani, Frank J. ....	54
Japanese Health Hazards .....	ab423
Jarrett, Harry † .....	165, 346
Jefferson Medical College of Philadelphia, 117th Annual Commencement .....	452
Jolliffe, Norman .....	174
Jones, Marion Fisher .....	114
Judicial Councilors (See Councilors)	

## K

Kalb, S. William, Newark .....	*74, 291, *584
Kaplan, J. Allen .....	160
Kaplan, S. Bernard, Newark .....	292, *493
Katz, J. D., Jersey City .....	*373
Katzin, E. M. ....	109
Kauffman, Jerome .....	649
Kennedy, Robert H. ....	298
Kenny Treatment of Poliomyelitis .....	43, 45, 512
Keratitis, Interstitial—Sherman .....	*485
Kern, E. Clarence .....	553
Kessler, Henry B. ....	343
Kilborn, Melville G. ....	109, 553
Kilduffe, Robert A. ....	5, 43, 343
Klein, Edward C., Jr., Newark .....	*144
Kler, Joseph H. ....	396
Kline, Oram R., Camden .....	*432
Knauer, C. H., Trenton .....	*75, 291
Kolmer, John A. ....	115
Kraemer, Manfred, Newark .....	*270, 343, 601
Krantz, John C., Jr. ....	553
Kruger, Alfred L. ....	508, 601

## L

Latham, Ruth M. ....	160
Legislative News .....	591, 631
Legislative Subcommittee .....	93, 105
Lehr, David .....	292
Lemmerz, Theodore H.† .....	42
Lemmon, William T. ....	115
Lessons from Schicklegruber .....	e569
Letters to The Journal .....	166

## M

MacDowall, John L.† .....	645
MacKenzie, Robert A., Asbury Park .....	*280, *587
Macleod's Physiology in Modern Medicine (P. Bard) .....	br180
Magennis, Bryan C.† .....	164
Mahaffey, J. Lynn .....	109, 455
Mahoney, Mrs. Madeline P. ....	292
Malaria, Control of, and Drug Monopoly .....	258
Malavazos, Antonio .....	109
"Malingers" .....	e314
Malpractice Actions, Restricted Coverage in .....	454
Markowitz, Irwin, Jersey City .....	*373
Marlett, N. C. ....	601
Marquis, W. James, Newark .....	291, *575
Marsh, Elias J. ....	160, e517, 638, 649
Biography .....	e249
Martin, Stevens J. ....	292, 553
Materia Medica, Toxicology, and Pharmacy, Synopsis of, for Students and Practitioners of Medicine (F. R. Davison) .....	br660
Maternal Mortality Statistics in New Jersey for 1941—Bingham .....	*539
Maternal Welfare Advisory Committee.....	102, 104
Maternal Welfare Articles— No. 66—Statistics on Other Accidents of Child- birth as a Cause of Maternal Mortality in New Jersey—Bingham .....	*33
No. 67—Statistics on Ectopic, Other Accidents of Pregnancy, Other Unspecified Conditions, and Embolism as a Cause of Maternal Mor- tality in New Jersey—Bingham .....	*87
No. 68—Radiology in Obstetrics—Perlberg...	*152
No. 69—The Cesarean Operation and the New Jersey Maternal Welfare Report—MacKen- zie .....	*280
No. 70—The Treatment of the Infertile Preg- nant Patient—Montgomery and Stewart...	*333
No. 71—Treatment of Recurrent and Threat- ened Abortion—Carrington .....	*387
No. 72—Rupture of the Uterus, a Study Based on Maternal Deaths in New Jersey, 1937- 1941—White .....	*446

- No. 73—The Management of Toxemias of Pregnancy—III .....\*502
- No. 74—Maternal Mortality Statistics in New Jersey for 1941—Bingham .....\*539
- No. 75—Ovarian Tumors Complicating Pregnancy—MacKenzie .....\*587
- No. 76—The Treatment of Abortion—Bingham.....\*624
- Maternity Care Standards and Employment of Mothers in Industry ..... 636
- Mathis, John H. .... 109
- Matthews, Robert A. .... 174
- Matthews, William F. .... 343
- May, Ernst A. .... 353
- Mayo Clinic and Mayo Foundation, Collected Papers of the ..... br564
- McCausland, Alexander ..... 601
- McCullough, John N. .... 44
- McGee, Lemuel C. .... 601
- McNeer, Gordon ..... 173
- McPhedran, F. Maurice ..... 46
- Mecray, Paul, Jr. .... 343
- Medical and Hospitalization Benefits for Veterans of World War II ..... 594
- Medical Care—  
for Crippled Children ..... 644  
for Wives and Children of Enlisted Men ..... e518, 554, 599  
of the Indigent Advisory Committee ..... 101  
for Women's Army Auxiliary Corps ..... 633  
Plans ..... 460
- Medical Clinic Service ..... e362
- Medical Defense During Air Raids ..... 136
- Medical-Dental Service Bureau ..... 348
- Medical Dictionary, American, Illustrated (Dorland and Miller) ..... br52
- Medical Dictionary, Stedman's Practical (rev. by S. T. Garber) ..... br612
- Medical Examiners, State Board of ..... 95, 111, 509
- Medical Examiners for Selective Service ..... 64
- Medical Gas Officer (Eastern States) ..... 472
- Medical Practice Subcommittee ..... 92, 99
- Medical Preparedness ..... 44, 91, 114, 172, 174  
Committee ..... 95  
in New Jersey ..... 259
- Medical Procurement and the A.M.A. .... 18
- Medical Schools, Accelerated Program of ..... ab379
- Medical Service Administration ..... e2, 91, 97, 168, 170, 172, 174, 638  
Moves ..... 107
- Medical Services, Organized, the Modern Trend Toward Better—Wilkes ..... 155
- Medical Society—  
in the Defense Program ..... 16  
Newark Offices of ..... 555
- Medical State and National Board Summary (W. H. Krupper) ..... br461
- Medical Surgical Plan of New Jersey ..... 352, 392
- Medical Teachers Wanted ..... ab322
- Medicine Chest Hazards in Blackouts ..... ab623
- Medicine Faces the Future—Wilkes ..... 400
- Medicine Is Ready ..... e2
- Medicine, Textbook of (edited by J. J. Conybeare) ..... br51
- Members—  
Now in War Services ..... e518
- Official List of ..... May Supplement
- Serving in the Armed Forces:  
List No. 1 ..... 340  
List No. 2 ..... 398  
List No. 3 ..... 453  
List No. 4 ..... 508  
List No. 5 ..... 555  
List No. 6 ..... 601  
List No. 7 ..... 643
- Supplementary List to the Official List—  
No. 1 ..... 292  
No. 2 ..... 342  
No. 3 ..... 397  
No. 4 ..... 454  
No. 5 ..... 508  
No. 6 ..... 556  
No. 7 ..... 603  
No. 8 ..... 643
- Mental Disease in the Army ..... 18
- Menzel, A. E. O. .... 292
- Mercer County Medical Society ..... 44, 116, 171, 648
- Metabolism, Diseases of: Detailed Methods of Diagnosis and Treatment (edited by G. G. Duncan) ..... br562
- Microbes Which Help or Destroy Us (Allen, Holtman and McBee) ..... br513
- Middlesex County Medical Society ..... 45, 116, 172, 298, 349, 407, 649
- Middlesex County Pharmaceutical Association ..... 45
- "Middletown Goes to War" Film ..... 604
- Military Rank, Initial, for Physicians ..... 468
- Military Surgeon's Prayer ..... 65
- Modarelli, W. H. .... 553
- Modern Trend Toward Better Organized Medical Services—Wilkes ..... 155
- Moffat, Barclay W.† ..... 645
- Monmouth County Medical Society ..... 45, 116, 172, 407, 649
- Montgomery, Thaddeus L., Philadelphia, Pa. ....\*333
- Moolten, Sylvan E. .... 160
- Moorhead, John J. .... 647
- Moriconi, Albert F., Trenton .....\*322, \*385
- Morrill, James P.† ..... 42, 173
- Morris County Medical Society ..... 45, 118, 173, 298, 349, 408, 606
- Morris, Watson B. .... 46, 353
- Mother's Charter ..... ab90
- Mount, Walter B. .... 601
- Moving Picture Films for Our Annual Meeting ..... 36
- Muller, George P., Philadelphia, Pa. ....\*27
- Municipal Aid Administration, Facts Concerning the Work of ..... 596
- Murray, Harrold A., Newark .....\*617
- My Friend Dr. Pottlesmith ..... e312
- Myomectomy During Pregnancy ..... ab284

\* Original article

† Obituary

ab—Abstract

e—Editorial

br—Book review

Annual Reports: April Journal

Official List: May Supplement

Transactions: August Supplement

## N

- Nails, Diseases of the (V. Pardo-Castello) . . . br50  
 Nasal Sinuses (O. Van Alyea) . . . br307  
 National Formulary. National Formulary VII br659  
 National Physicians Committee . . . 166  
 Naval Appointments Open to Medical Students. 253  
 Naval Reserve—  
   Appointments Open to Medical and Dental  
     Students . . . 254  
   Appointments Open to Medical Doctors . . . 254  
   Special Courses for Medical Officers . . . 470  
 Naylor, Mildred V. . . 160, 396, 553  
 Neare, Clifford R.† . . . 645  
 Neffson, A. Harry . . . 45  
 Negro Health . . . 103, 105  
 Negro Health and Chest X-Rays . . . 348  
 Nelson, John B. . . . 553  
 Neonatal Deaths in New Jersey in 1940—Levy  
   398, e417  
 Nephritis (L. Lichtwitz) . . . br563  
 Nervous System Diseases (F. M. R. Walshe) br126  
 Nesselrod, J. R. . . . 343  
 Neuro-anatomy (F. A. Mettler) . . . br180  
 Neuropsychiatric Problem of the Army—Fact,  
   Functional or Fake—Brussel . . . \*442  
 Neuroses—  
   and Bombs . . . 67  
   and Psychoses in Wartime—Trippe . . . \*524  
   in Wartime, Less . . . 418  
 Neurosyphilis in Relation to Ophthalmology—  
   Levy . . . \*581  
 Nevius, William B. . . . 161  
 New Jersey Chapter of the American College of  
   Chest Physicians . . . 343, 650  
 New Jersey Medical Authors . . . 109, 160, 291  
   342, 396, 507, 553, 601, . . .  
 New Jersey Physicians, Attention! . . . 135  
 New Jersey Physicians Committee Formed. . . 38  
 New Jersey Tuberculosis League—Pollak . . . 393  
 Newark Offices of The Medical Society . . . 555  
 Newman, Julius . . . 601  
 Next Step for Physicians . . . 61  
 Nichols, Stanley . . . 508  
 Nicola, Toufick . . . 508  
 Night of Flame (D. Carter) . . . br514  
 No More Than 1500 People Should be Served by  
   One Doctor . . . 470  
 Nocturnal Angina—Rubin . . . \*529  
 Noone, Ernest L. . . . 296  
 Norton, J. F. . . . 161  
 Nurses—  
   Aides . . . 472  
   Employment of, in Approved Schools of Nurs-  
     ing . . . 162  
   Needed to Teach Red Cross Nursing . . . 17  
 Nursing and Nursing Education Advisory Com-  
   mittee . . . 99  
 Nutritional Deficiencies: Diagnosis and Treat-  
   ment (Youmans and Patton) . . . br562

## O

- Obesity, Amphetamine (Benzedrine) Sulphate  
 and Thyroid Extract in the Treatment of—  
   Kalb . . . \*74  
 Obesity, Effect of Amphetamine (Benzedrine)  
   Sulphate, Propadrine Hydrochloride and  
   Propadrine Hydrochloride in Combination  
   with Sodium Delvinal on the Appetite—  
   Kalb . . . \*584  
 Obstetrics and Gynecology, 1941 Year Book (ed-  
   ited by DeLee and Greenhill) . . . br411  
 Obstetrics, Radiology in—Perlberg . . . \*152  
 Occupational Diseases; Diagnosis, Medicolegal  
   Aspects and Treatment (R. T. Johnstone) br305  
 Occupational Diseases, Essentials of (Reed and  
   Harcourt) . . . br461  
 Ocean County Medical Society . . . 173, 350, 561  
 Ocean County Transfusion Fund . . . e3, 36  
 O'Crowley, Clarence . . . 347  
 Officers, Current List of . . . 506  
 Officers, List of (Advertising p. 3A each issue of  
   *The Journal*)  
 Official List . . . May Supplement  
 Operative Surgery (edited by F. W. Bancroft) br51  
 Ophthalmology, Neurosyphilis in Relation to—  
   Levy . . . \*581  
 Opifereque per Orbem . . . 342  
 Oral Cavity, Pathology of (L. R. Cahn) . . . br462  
 Orris, Harold J. . . . 292  
 Orthopedic and Industrial Surgery, 1941 Year  
   Book of (edited by C. F. Painter) . . . br612  
 Orton, Henry Boylan . . . 601  
 Osteomyelitis of Skull—Pomeranz . . . \*436  
 Osteopaths and Procurement and Assignment . . 571  
 Our Big Chance . . . e518  
 Ovarian Tumors Complicating Pregnancy—Mac-  
   Kenzie . . . \*587

## P

- Pack, George T. . . . 299  
 Pagliughi, J. J. . . . 292  
 Palm, Howard F.† . . . 126, 295  
 Palsy, Complete Facial, Post-operative, with Re-  
   covery—Moriconi . . . \*322  
 Paper Phobia . . . e59  
 Parasitology, Clinical Textbook of (D. L. Bel-  
   ding) . . . br412  
 Paregoric Sale Controlled by Canada . . . ab265  
 Paragon "Work by the Side of Work" . . . 345  
 Parker, Douglass B. . . . 350  
 Parry, O. K. . . . 117  
 Parsonnet, Aaron E. . . . 396, 601  
 Passaic County Medical Society . . . 46, 118, 173,  
   299, 350, 409, 607, 649  
   Radio Project . . . 37  
 Pathological Chemistry, Applied, Synopsis of  
   (Andes and Eaton) . . . br411  
 Pathology and Immunology, 1941 Year Book  
   (Karsner and Hooker) . . . br124  
 Paying or Not Paying the Doctor . . . ab445  
 Payne, Franklin . . . 170



- Peace on Earth Good Will Toward Men..... e616
- Pearl Harbor Attack, Treatment of Casualties... 647
- Pediatric Convention ..... 108
- Pediatric Gynecology (G. C. Schauffler) .....br514
- Pediatrics, New Jersey Fellows of the American Academy, Annual Meeting ..... 161
- Pediatrics, Textbook of (Griffith and Mitchell) br123
- Penalty or a Privilege? ..... e57
- "Peptic Ulcer" Film ..... 604
- Pericarditis, Adhesive, Anginal Pain Due to—Eigen and Abel .....\*439
- Perineopelvic Anatomy from the Proctologist's Viewpoint (R. V. Gorsch) .....br357
- Peripheral Vascular Disease—Differential Diagnosis in—Dinge ..... \*30
- Peritonitis, General, Treatment of, of Appendiceal Origin—Tether .....\*331
- Perkel, Louis L., Jersey City .....\*488
- Perkins, William H. ....115, 295
- Perlberg, H. J., Jersey City .....\*152
- Pessel, J. F. ....343
- Pest, The .....e416
- Pharmaceutical Problems Advisory Committee 101, 549, 555
- Pharmacology, Manual of, and Its Application to Therapeutics and Toxicology (T. Solmann) .....br612
- Pharmacopoeial Convention ..... 163
- Pharmacy and Civilian Defense ..... 16
- Pheasant, Homer C. .... 601
- Physical Fitness, Shortcomings in Campaign for 260
- Physical Therapy Technicians ..... 460
- Physician Examine Thyself ..... e518
- Physician Have Thyself Examined ..... e570
- Physicians—
- Allocation of ..... 631
- in Industrial Medicine ..... 522
- Wanted as Instructors ..... 15
- Pitkin, George P. .... 161, 292
- Plastic and Maxillofacial Surgery, Manual of Standard Practice of .....br513
- Plume, C. A. .... 601
- Plummer, Norman ..... 118
- Pneumonia Serum Available ..... 112
- Pneumonia Therapy, Present Status of ..... 39
- Pellak, B. S. .... 393
- Pomeranz, Raphael, Newark .....\*436
- Pons, C. A. .... 553
- Postencephalitis Parkinsonism, Methods of Treatment in (H. D. von Witzleben) .....br412
- Post-Graduate Industrial Medicine ..... 597, 634
- Post-operative Complete Facial Palsy with Recovery—Moriconi .....\*322
- Potter, Benjamin P. .... 292, 508
- Pottlesmith, Dr., My Friend ..... e312
- Practice and Precept ..... e130
- Practitioner, General, and Gastroscopy—Heinken .....\*138
- Praise for Dr. Schlichter ..... 642
- Pratt, Gerald H. .... 353
- Precept and Practice ..... e130
- Pregnancy and Myomectomy ..... ab284
- Pre-Induction Test Cancelled for March... 137
- President's Message ..... e517
- Price, H. P. .... 161
- Price, Preston ..... 291, 508
- Primer on the Prevention of Deformity in Childhood (Raney and Shands) .....br306
- Privilege or a Penalty? ..... e57
- Procurement and Assignment Service ..... 61, 62, 67, 115, 131, 135, 365, 470, 521, 571, 572, 642
- Enrollment Form ..... 4
- in New Jersey ..... 315
- Procedure in ..... 454
- Procurement of Physicians ..... e361
- Promotions for Doctors in Service ..... e467
- Propadrine Hydrochloride and Propadrine Hydrochloride in Combination with Sodium Delvinal and Amphetamine (Benzedrine) Sulphate in the Treatment of Obesity—Kalb .....\*584
- Prophecy, A ..... e363
- Protector or Policeman ..... e314
- Protzman, Colonel ..... 117
- Prout, Thomas P., Summit ..... 40, 109, \*376
- Psychiatric Social Work (L. M. French).....br307
- Psychiatry and the General Hospital—Gordon... \*84
- Psychology of Dealing with People (W. White) .....br660
- Psychoses and Neuroses in Wartime—Trippe \*524
- Public Health—
- in Wartime—Williams .....\*619
- News ..... 604
- 1941 Year Book (edited by J. C. Geiger)....br51
- Subcommittee .....92, 102, 549
- Consultants to Advisory Committees ..... 549
- Public Relations Subcommittee ..... 94, 106
- Puerperal Sepsis, Sulfonamids in ..... ab151
- Putnam, Tracy Jackson ..... 43
- Pyloric Obstruction, Medical Management of ab375

## Q

- Quinine Restrictions—Ulmer ..... 555
- Quirk, Martin ..... 54

## R

- Rabe, Rudolph F. .... 553
- Radiology in Obstetrics—Perlberg .....\*152
- Rados, Andrew ..... 292
- Raffetto, Joseph ..... 508
- Rake, Geoffrey ..... 292
- Read, Hilton S. .... 43, 166, 168, 170, 171, 172, 346
- Reading the Rejection Rate ..... e58
- Rectum. Cancer, Some Problems in the Management of—Silvers .....\*323
- Reference Committees ..... 237
- Also see Transactions
- Rehabilitation of Selective Service Rejectees 523, 574
- Rehabilitation, Vocational ..... 593
- Reich, A. L., Newark .....\*326
- Reich, Mortimer, Newark .....\*261
- Reimann, Hobart A. .... 44

Reitman, Norman ..... 396  
Rejection Rate, Reading the ..... e58  
"Relativity" with Apologies to Einstein ..... e313  
Reporters, County Society ..... 605  
Research ..... e251  
Responsibility of the Medical Profession To-  
wards the Political Institutions of the Na-  
tion—Eagleton ..... \*63  
Rhoads, Jonathan E. .... 295  
Riboflavin, Large Doses, and Pathological  
Changes in the Urinary Tract—Antopol ..... \*285  
Ripps, Maurice L.† ..... 645  
Robbin, Lewis ..... 292  
Robbins, Charles M., Newark ..... \*473  
Robertson, Jeffrey M. .... 349  
Roemer, Milton I., Trenton ..... 54, 343, \*498  
Roentgen Ray Diagnosis of Lesions of the Stom-  
ach and Duodenum, the Correlation of, with  
the Operative Findings—Marquis and Baker \*575  
Roentgen Treatment of Infections (Kelly and  
Dowell) ..... br358  
Rogers, Lawrence H. .... 109  
Rorschach Test, Clinical Application of (Boch-  
ner and Halpern) ..... br308  
Roseman, Herman I. .... 161  
Rosenberger, Randle C. .... 43  
Roth, J. J. .... 109  
Rubin, Benjamin, South River ..... \*529  
Rubin, Mitchell ..... 44  
Rundlett, Emilie ..... 508  
Rupture, Traumatic, of a Hydrocele—Cook and  
Hewson ..... \*142  
Russian War Relief ..... 317

S

Sacco, A. G. .... 292  
Sachs, Wilbert ..... 508  
Salem County Medical Society .... 46, 118, 299, 351  
Schaaf, Royal A., Newark ..... \*76, 291  
Schickleguber, Lessons from ..... e569  
Schiffrin, Arthur ..... 601  
Schlichter, Charles H. .... 642, 649  
School Bus Ambulances ..... 260  
School Medical Service, Improvement in—  
V ..... 41  
VI ..... 110  
Schumann, Edward A. .... 169, 346  
Scientific Exhibits Awards ..... 289  
Scientific Work Committee ..... 549  
Scott, Norman M. .... 44, 168, 171, 346, 352, 642, 647  
Scudder, Frank D.† ..... 164  
Scudder, John ..... 173, 298  
Second Corps Area Chairman ..... 604  
Secretaries' and Editors' Conference ..... 639  
Seeley, Sam F. .... 62  
Transferred ..... 574  
Segmental Enteritis—Robbins and Dreskin ..... \*473  
Selective Service Rejectees Can Be Rehabili-  
tated ..... 523  
Serology in Syphilis Control (R. L. Kahn) ..... br513  
Sharp, Reuben ..... 351  
Shaul, John F. .... 508

Sherman, A. Russell ..... 343  
Sherman, Elbert S., Newark ..... \*485  
Shipman, James S. .... 346  
Shipp, H. P. .... 46  
Shirlock, Margaret E. .... 647  
Shivers, Charles deT. .... 109  
Silver, Harry ..... 54  
Silvers, Homer I., Atlantic City ..... \*323  
Simmond's Disease, a Case of Hypophyseal De-  
ficiency Resembling—Prout and Thomson .. \*376  
Sinnott, Gerald W. .... 460  
Skeletons ..... e417  
Skull, Osteomyelitis of—Pomeranz ..... \*436  
Smith, Alan DeForest ..... 350  
Smith, Warren Hastings † ..... 510  
Smoking in Wartime ..... 403  
Snegeriff, Leonid S. .... 135  
Social Security Act Amendments of 1942 ..... 591  
Sodium Delvinal in Combination with Propad-  
rine Hydrochloride and Propadrine Hydro-  
chloride, and Amphetamine (Benzedrine)  
Sulphate in the Treatment of Obesity—  
Kalb ..... \*584  
Somerset County Medical Society ..... 174, 351, 410  
Old Records ..... 174  
Sorg, Mr. H. Theodore ..... 352  
Sommer, George N. J., Jr., Fort Dix ..... 161, 291, \*365  
Specialist, The ..... e130  
Speed Up ..... e311  
Sperling, Irving L., Newark ..... \*538  
Splenectomy in Gaucher Splenomegaly, Indica-  
tions for—Wilensky ..... \*531  
Sprague, Seth B. .... 161  
Statistics on Ectopic, Other Accidents of Preg-  
nancy, Other Unspecified Conditions, and  
Embolism as Causes of Maternal Mortality  
in New Jersey—Bingham ..... \*87  
Stedman's Practical Medical Dictionary (rev. by  
S. T. Garber) ..... br612  
Stewart, Harry L., Jr., Philadelphia, Pa. .... \*333  
Stimson, Phillip N. .... 43, 45  
Strecker, Edward A. .... 297  
Strelinger, Alexander ..... 601  
Stroud, William D. .... 346  
Sturr, Robert ..... 173  
Stuttering ..... ab73  
Subarachnoid Hemorrhage, Spontaneous—  
Hirschfield, Tornay and Yaskin ..... \*494  
Successful Demonstration ..... e466  
Sulfa Drugs in Dermatology ..... 353  
Sulfanilamid and Related Compounds in Gen-  
eral Practice (W. W. Spink) ..... br52  
Sulfathiazole in Infantile Diarrhea ..... ab330  
Sulfonamid Suppository in Acute Gonorrhea in  
Women ..... ab273  
Sulfonamids in Puerperal Sepsis ..... ab151  
Summit Medical Society .... 46, 175, 300, 353, 410, 607  
Supplements to Journals—  
Official List of Members ..... May  
Transactions ..... August  
Supreme Court to Review Questions Related to  
Practice of Medicine ..... 598

Surgeons, American College of, Approved Hospitals .....	141
Surgeons Society of New Jersey, Annual Meeting .....	159
Surgery—	
of the Ambulatory Patient (Ferguson and Kaplan) .....	br612
General, Essentials of (W. P. Ritchie) .....	br124
Textbook of, by American Authors (edited by F. Christopher) .....	br412
Surgical Patients, Synopsis of the Preparation and Aftercare of (Ilgenfritz and Penick) .....	br50
Surgical Practice of the Lahey Clinic, Boston, Mass. ....	br462
Sussex County Medical Society .....	300
"Sutures Since Lister" Film .....	345
Swiney, M. ....	553
Syphilis—	
Intensive Arsenotherapy of, in New Jersey Hospitals—Roemer .....	*493
Intensive Treatment of .....	ab435
of the Nose and Mouth—Kline .....	*432

## T

Taber, Leslie R. ....	54
Taylor, Robert .....	161
Temporary Licenses to Practice the Healing Art in the District of Columbia .....	e520
Tetanus Mortality, Reducing .....	ab79
Tether, Russell K., Closter .....	*331
Thomson, Carrell S., Summit .....	*376
Thorax, War Wounds of, Treatment of—Sommer .....	*365
Thrombophlebitis, Treatment of—Hawkes .....	*328
Thyroid Extract and Amphetamine (Benzedrine) Sulphate in the Treatment of Obesity—Kalb .....	*74
Thyrotoxicosis and Ergot .....	ab279
Timely Topics .....	595, 634
Tonsillectomy, Effect of, on Respiratory Infections in Children .....	ab582
Tornay, A. S., Philadelphia, Pa. ....	*494
Town Hall of Essex County Program .....	558
Townsend, Leslie .....	601
Toxemia of Pregnancy, Preëclamptic and Eclamptic (Dexter, Weiss, et al.) .....	br412
Toxemias of Pregnancy (W. J. Dieckmann) .....	br357
Toxemias of Pregnancy, The Management of—	
Ill .....	*502
Traffic Accidents Advisory Committee .....	42, e59, 102, 108
Transactions .....	August Supplement
Transactions, Annual Meeting .....	e415
Transporting Human Blood .....	ab327
Trauma and Disease (Brahdy and Kahn) .....	br513
Treatment of the Patient Past Fifty (E. P. Boas) .....	br611
Trippe, Clarence M., Asbury Park .....	*524
Trustees' Meeting .....	550
Tuberculosis—	
Abstracts .....	55, 127, 181, 248, 309, 359, 413, 463, 515, 565, 613, 661
Control Advisory Committee .....	102, 549

Modern Attack on (Chadwick and Pope) .....	br563
Story of Clinical Pulmonary (L. Brown) .....	br50
Tuchman, Lester .....	601
Typhus. Active Immunization Against .....	ab372

## U

Ulmer, Chester I. ....	166, 555
Union County Medical Society .....	174, 300, 351, 649
United States Public Health Service Reserve Commissions .....	641
Unna, Klaus .....	291, 553
Urethral Anomalies .....	ab143
Urinary Tract—	
Infections, Modern Treatment of—Reich .....	*261
Pathological Changes, Following Large Doses of Riboflavin—Antopol .....	*285
Pathology Associated with Carcinoma of the Cervix—Markowitz and Katz .....	*373
Urology Award .....	646
Urology in War, Wounds and Other Emergencies of the Genito-Urinary Organs, Surgical and Medical (C. Y. Bidgood) .....	br462
Uterine and Vaginal Prolapse—Walscheid .....	*274
Uterus, Rupture of the—A Study Based on Maternal Deaths in New Jersey, 1937-1941—	
White .....	*446

## V

Vaginal and Uterine Prolapse—Walscheid .....	*274
Vascular Manikin, Display of .....	39
Vasodilatation and Diathermy .....	ab487
Venereal Disease Control Advisory Committee .....	102
Venous Pressure, Circulation Time and—Klein .....	*144
Vitamin Films in Color .....	290
Vitamin Treatment of Fibrositis .....	ab141
Vocational Rehabilitation .....	593

## W

Walker, Evelyn T. ....	117
Walker, Harold .....	54
Walscheid, Arthur J., Union City .....	*274
Wangensteen Suction Drainage, A New Use for—Weinberg and Sperling .....	*538
War—	
Effort or Reform .....	e568
Gases: Their Identification and Decontamination (M. B. Jacobs) .....	br564
Information, Office of .....	572
Medicine; A Symposium .....	br612
Section of The Journal .....	4, 61, 131, 252, 315, 365, 418, 468, 521, 571
Wounds of the Thorax, Treatment of—Sommer .....	*367
Warren County Medical Society .....	650
Waters, Edward G. ....	292, 343
Weight Reducer, Complete (C. I. Gerling) .....	br125
Weinberg, C. Richard, Newark .....	*538
Weiss, Edward .....	348
Welfare Committee—	
Meeting—January 18, 1942 .....	91
Meeting—September 27, 1942 .....	550



"Well Done, Thou Good and Faithful Servant".	397	Hudson County	122, 178, 354
What Is The Medical Society Doing with My		"M" Is for Mercer County	303
Dues	e364	"M" Is for Middlesex County	303
White, Robert R., East Orange	*446	"O" Is for Ocean County	354
White, Thomas J.	291	"P" Is for Passaic County	354
Whiteleather, Melvin	116	Passaic County	356
Whooping Cough and Diphtheria, Simultaneous		Program	609
Immunization Against	ab441	1942-1943	651
Wild, Frederick A.	459	Public Relations	48
Wilder, Mildred E.	343	Questionnaire	121
Wilensky, Abraham O., New York, N. Y.	*531	State Board Meeting	119, 609
Wilkes, LeRoy A.	44, 155, 173, 349, 400, 505	State Nursing Association in Defense	120
	548, 590, e615, 630	Stronger Not Weaker	608
Williams, R. C., New York, N. Y.	553, *619	Union County	178
Williams, Robert R.	175	"W" Is for Warren County	355
Wilson, George	347	War, Morale, Thumbs Up	176
Wolf, I. J.	54	Women, Diseases of (Crossen and Crossen)	br411
Wolffe, Joseph B., Philadelphia, Pa.	*266, 299	Women's Army Auxiliary Corps, Medical Care	
Woman's Auxiliary (also see Transactions)—		for	633
Allman, Mrs., Salute to	302	Workmen's Compensation Advisory Committee	101
Annual Meeting Program	237	Wound Infections—Diagnosis and Treatment—	
Annual Meeting Report	301	Deibert	*319
Atlantic County	48, 355	Write, The Itch to—Davidson	*380
Auxiliary Defense Project, Why Not an?	302		
Bergen County	49		
Bulletin	48		
Camden County	121, 177, 355, 410		
Coming Events	47, 119, 176, 301, 608		
Conventions Galore	177		
Down with the County Lines	354		
Emergency Medical Field Sets Donated by			
Auxiliary	610		
"E" Is for Essex County	47		
Essex County	49, 178, 610		
"G" Is for Gloucester County	120		
Gloucester County	49, 356		
"H" Is for Hudson County	177		

## X

X-Ray Therapy of Chronic Arthritis (K. Gold-	
hamer)	br51
X-Rays in Somerset County	98

## Y

Yachnin, S. C.	54, 650
Yaskin, J. C., Philadelphia, Pa.	171, *494
Young Men Are in Demand	e570

## Z

Zvaifler, Nathan	292
------------------	-----

1-56—Jan.  
57-128—Feb.  
129-182—Mar.  
183-248—Apr.

249-310—May  
311-360—June  
361-414—July  
415-464—Aug.

465-516—Sept.  
517-566—Oct.  
567-614—Nov.  
615-676—Dec.

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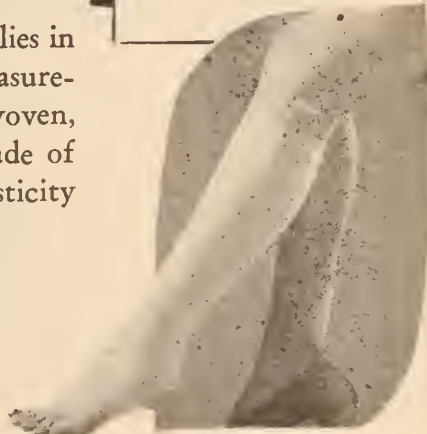
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